QUALITY STRATEGY, ASSESSMENT AND PERFORMANCE IMPROVEMENT REPORT

DRAFT

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Executive Summary

In accordance with Code of Federal Regulations 42 CFR 438.200 et. seq., the Arizona Health Care Cost Containment System (AHCCCS) Quality Strategy was first established in 2003. Since that time, it has been revised as appropriate to reflect innovative approaches to member care and continuous quality improvement efforts. AHCCCS's Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. It is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. In addition, the Quality Strategy leads to the identification and documentation of issues related to those standards, and encourages improvement through incentives, or when necessary, through regulatory actions.

The Quality Strategy supports the mission and vision of AHCCCS and is aligned with the Agency's Strategic Plan which outlines overarching goals that guide the Agency's direction for state fiscal years 2015-2019. This report outlines AHCCCS's commitment to transparency, stakeholder engagement, and ultimately a commitment to the provision of quality care and services to those served through Arizona's Medicaid Managed Care and Fee for Service systems.

Since 2003, the emphasis of AHCCCS's Quality Strategy has shifted from process measures to more comprehensive outcome-based measurement and innovative delivery system design. The Quality Strategy provides a framework for improving and/or maintaining members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy through stakeholder presentations and public comments. The Quality Strategy incorporates all required elements outlined in 42 CFR §438.340.

Several AHCCCS Divisions are responsible for the implementation and oversight of the Quality Strategy. Internal and external collaborations/partnerships are utilized to address specific initiatives and/or issues. The Agency maintains the ultimate authority for overseeing the Quality Strategy implementation and direction, including evaluation of overall effectiveness and Managed Care Organization (MCO) adherence. AHCCCS is responsible for reporting Quality Strategy activities, findings, and actions to members, other stakeholders, MCOs, the Governor, legislators, and The Centers for Medicare and Medicaid Services (CMS). AHCCCS posts the Quality Strategy and related reporting to its website to ensure transparency.

1. AHCCCS Overview

1.1 Agency Vision

Shaping tomorrow's managed health care…from today's experience quality and innovation

1.2 Agency Mission

Reaching across Arizona to provide comprehensive, quality health care for those in need

1.3 Agency Values

- **Passion**: Good health is a fundamental need of everyone. This belief drives us, inspires and energizes our work.
- **Community**: Health care is fundamentally local. We consult and work with, are culturally sensitive to and respond to the unique needs of each community we serve.
- **Quality**: Quality begins as a personal commitment to continual and rigorous improvement, self-examination, and change based on proper data and quality improvement practices.
- **Respect**: Each person with whom we interact deserves our respect. We value ideas for change, and we learn from others.
- **Accountability**: We are personally responsible for our actions and understand the trust our government has placed on us. We plan and forecast as accurately as possible. Solid performance standards measure the integrity of our work. We tell the truth and keep our promises.
- **Innovation**: We embrace change, but accept that not all innovation works as planned. We learn from experience.
- **Teamwork**: Our mission requires good communication among interdependent areas inside and outside the agency. Internally, we team up within and across divisions. Externally, we partner with different customers as appropriate.
- **Leadership**: We lead primarily in two ways: by setting the standards by which other programs can be judged, and by developing and nurturing our own future leaders.

1.4 Agency Strategic Plan Goals

Strategic Goal 1: *AHCCCS must pursue and implement long term strategies that bend the cost curve while improving member health outcomes.*

Strategic Goal 2: *AHCCCS must pursue continuous quality improvement.*

Strategic Goal 3: *AHCCCS must reduce fragmentation, driving toward an integrated healthcare system.*

Strategic Goal 4: *AHCCCS must maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations.*

1.5 Background

Arizona was the last state to implement a Medicaid program and the first state to utilize a managed-care approach starting from AHCCCS' inception in 1982. Arizona added a fully integrated program for physical and behavioral health services and long term supports and

services under managed care in 1989 by creating the Arizona Long Term Care System (ALTCS) Program, which serves individuals who are intellectually/developmentally disabled as well as those that are elderly/physically disabled. All Medicaid services are provided under an 1115 Waiver as provided by the Social Security Act.

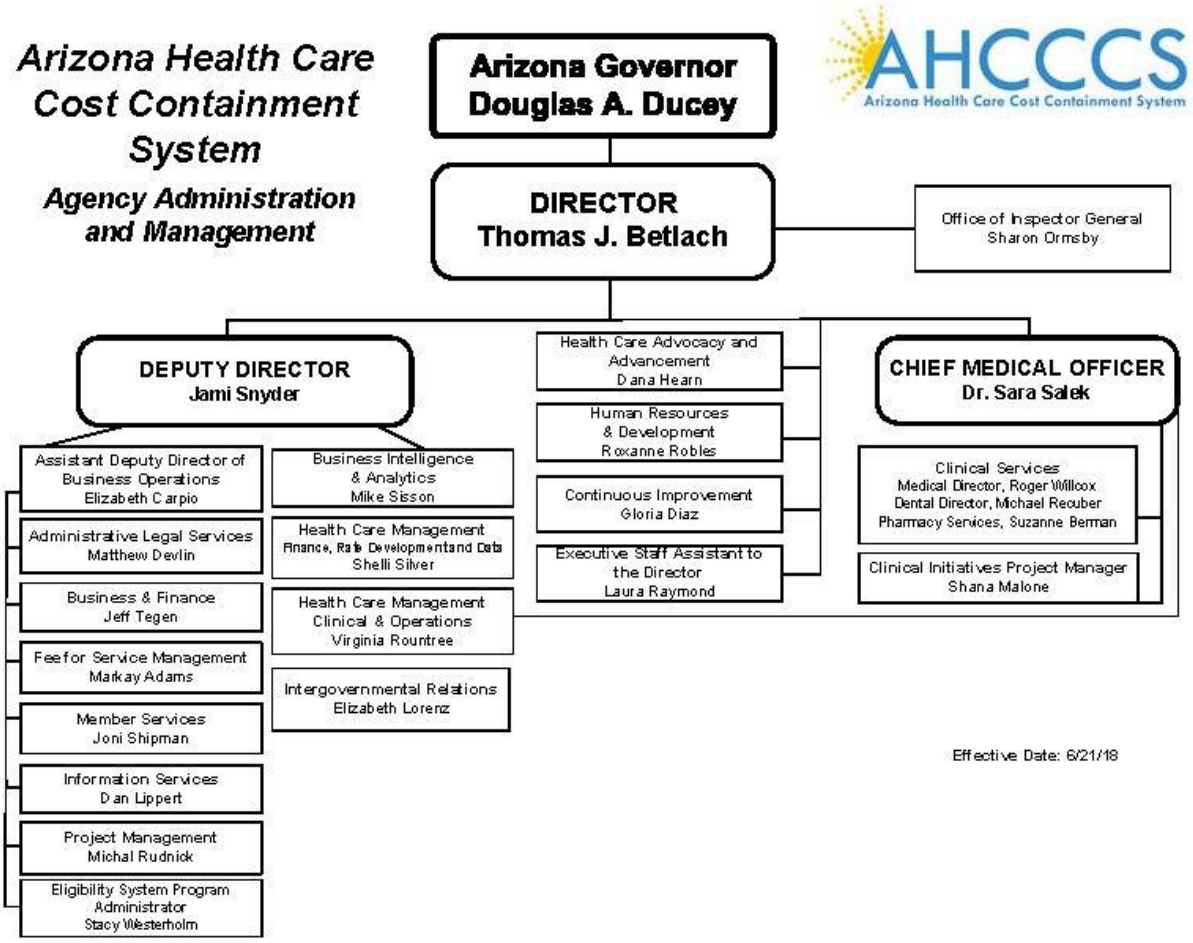
AHCCCS has been on a continual path to reduce fragmentation across its delivery system. In 2016 Arizona Governor Doug Ducey identified the efficiencies that would be recognized from the simplification of two state agencies, AHCCCS and the Division of Behavioral Health Services. Through the merger of these two state agencies, the integration of the oversight and management of both physical and behavioral health services including management of federal grant and state funded programs was successfully implemented in July 2016.

AHCCCS believes that health care delivery system design is essential to improving outcomes for members while assuring that the quality care provided is cost effective and easy for members and families to access. Integrated managed care organizations able to address the whole health needs of our state's Medicaid population are essential to reducing the fragmentation within the system and improving service delivery to members. As was achieved with the integration of physical and behavioral health services for Children's Rehabilitative Services (CRS) and individuals with Serious Mental Illness (SMI), AHCCCS continues to weave fragmented parts of service delivery together to create a more effective health care system. AHCCCS' efforts to further integrate care delivery systems and properly align incentives are designed to transition the structure of the Medicaid program to improve health outcomes and better manage limited resources. Effective October of 2018, AHCCCS will implement fully integrated physical and behavioral health managed care contracts for 1.5 million AHCCCS members under Arizona Complete Care.

Further, AHCCCS believes that not only is integration at the administrative and managed care level key in reducing the fragmentation of the delivery system but, promoting and supporting efforts of providers to deliver integrated services through primary care, integrated clinics, health homes and other models and the utilization of innovative reimbursement models are critical to a delivery system that can address the whole health needs of members. AHCCCS looks to numerous initiatives to support providers in this effort.

1.6 Agency Organizational Overview

AHCCCS maintains a strong organizational structure that is committed to implementation and oversight of programs that service AHCCCS members. The Quality Strategy's implementation is overseen by AHCCCS Executive Management with specific responsibility assigned to the Chief Medical Officer and Division of Health Care Management (DHCM). Refer to Agency Administration and Management Organizational Chart below.



1.7 The Director and the Executive Management Team

The Director has overall responsibility for ensuring that the Agency meets the established goals of the Strategic Plan and ensures the organization maintains the administrative infrastructure to meet the needs of the Agency. The Director works in collaboration with Executive Management (the Agency Deputy and Assistant Deputy Directors and all Division Assistant Directors) to manage the business and develop and implement administrative policies and procedures to support the delivery of quality health care services to the 1.9 million Medicaid members.

1.8 The Chief Medical Director

The Medical Director is a key position within AHCCCS Executive Leadership and works collaboratively across Divisions providing oversight of the quality and delivery of healthcare services as well as development and approval of medical policy.

1.9 Division of Health Care Management (DHCM)

The Division of Health Care Management (DHCM) is responsible for procurement of MCOs, contract and policy development, and MCO oversight and monitoring. All units within DHCM play a role in the development and adherence to the Agency's Quality Strategy. Key units include Finance, Data Analysis, Clinical and Operations. The Operations and Clinical Units with the Division established and work with the focus of the following visions:

Clinical Vision:

Improving member outcomes through strategic leadership, quality innovations and integrated care.

Operations Vision:

Optimizing member outcomes through an innovative integrated system of care.

1.10 Investigations - QM/OIG Relationship

AHCCCS Office of Inspector General (OIG) reports directly to the Director and coordinates with DHCM on different aspects of the quality strategy. Any potential quality of care issues are forwarded from OIG to the DHCM Quality Management (QM) unit for their review. OIG also receives referrals for any matters that QM identifies that may indicate fraud, waste, or abuse. OIG coordinates with QM for any areas of concern, operational reviews of the MCO for program integrity requirements, or education for correct operational flow.

Once the QM unit is notified by AHCCCS OIG of a need to suspend and/or terminate a provider, the QM unit contacts each MCO to identify how many members are assigned and/or receiving services from the provider. MCOs are also queried regarding their network capacity to transition the members to an appropriate provider that can meet their needs and anticipated time frames for safe member transition. AHCCCS QM tracks all notifications and transitions through completion of the process and then notifies AHCCCS OIG that member transition activities have been completed along with resolution of access to care and services. OIG also coordinates the same questions and processes through Division of Fee for Service Management (DFSM) for populations not addressed by the MCOs.

1.11 AHCCCS Relationship with CMS

AHCCCS's Office of Intergovernmental Relations (OIR) coordinates with CMS regarding its governing documents: the Medicaid State Plan; the Children's Health Insurance Program (CHIP), known as KidsCare in Arizona; and the Section 1115 Waiver. The State Plans describe how AHCCCS is administering Medicaid and CHIP in accordance with the Social Security Act and all other applicable laws.

Section 1115 of the Social Security Act provides states the flexibility to implement and test new approaches to administrating Medicaid, that can or may depart from existing federal rules, but which facilitate consistency with the overall goals of the Medicaid program. The primary goal of the AHCCCS 1115 Waiver Demonstration is to provide, through the employment of managed care models, quality health care services to all Medicaid and CHIP eligible members in a cost effective manner. In order to evaluate the effectiveness and success of the waiver and to identify future opportunities for improvement, OIR works closely with CMS to develop reports that monitor the progress and success of each Waiver. OIR also works collaboratively with CMS for the approval of new Waiver requests and amendments to existing Waivers.

1.12 Populations Served

a. ACUTE Care (AHCCCS Complete Care, effective 10/1/18)

The AHCCCS Acute Care program includes the provision of physical and behavioral health care services for Arizona residents that are eligible based Federal Poverty Level (FPL) categories and resource criteria. To qualify children and/or adults must:

- Be a citizen or qualified immigrant
- Have a social security number or apply for one
- Apply for all cash benefits that one may be entitled to such as pensions or Veteran Assistance benefits

b. Title XXI ("Kids Care")

To qualify an individual must:

- Be under 19 years of age and living in a household with an income under 200% of FPL

c. Children's Rehabilitative Services (CRS)

To qualify a member must:

- Have an eligible CRS covered condition that requires active treatment
- Be an AHCCCS-eligible child or adult up to the age of 21

d. Arizona Long Term Care System (ALTCS)

ALTCS (Arizona Long Term Care System) provides long term care supports and services to financially and medically eligible Arizona residents who are aged, blind, disabled, or have an intellectual/developmental disability. To qualify for non-financial eligibility an individual must:

- Be in need of a nursing home level of care as determined by AHCCCS
- Be a citizen or qualified immigrant
- Have a social security number or apply for one
- Be a resident of Arizona and apply for all cash benefits that one may be entitled to such as pensions or Veteran Assistance benefits
- Live in an approved living arrangement, such as one's own home, or an AHCCCS certified nursing facility or assisted living facility

e. AHCCCS Fee for Service

While the vast majority of AHCCCS populations are managed under a MCO, approximately 11 percent of AHCCCS membership is under fee for service management. The AHCCCS Division of Fee for Service Management (DFSM) is responsible for the clinical, administrative and claims functions of the Fee-For-Service population (FFS) of more than 205,000 members. This includes American Indians enrolled in the American Indian Health Program (AIHP) for acute care and integrated physical and behavioral services (effective 10/1/2018), members enrolled with the Tribal Regional Behavioral Health Authorities (TRBHAs) for behavioral health services and Tribal long term care programs, and individuals in the Federal Emergency Service (FES) program.

f. AHCCCS American Indian Health Program (AIHP)

AHCCCS American Indian and Alaskan Natives (AI/AN) Fee-For-Service (FFS) provides medically necessary services, including preventive and behavioral health services. Members may receive health care services from Indian Health Facilities (the Indian Health Service, tribally-

operated "638" health programs, urban Indian health clinics) and from other AHCCCS-registered providers. Members are not limited to a network and may switch their enrollment between AHCCCS AIHP and an AHCCCS MCO at any time. However, a member can change from one MCO to another only once a year.

2. AHCCCS Quality Strategy

2.1 Quality Strategy Scope and Objectives

The AHCCCS Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality throughout the AHCCCS system. AHCCCS achieves goals outlined in the Strategy through combined methods of partnership with and regulatory oversight of contracted MCOs, creation of value-based program development, and a focus on outcomes and optimized member health. AHCCCS clearly outlines expectations for quality care and service delivery and has structured a thorough and multi-faceted approach for monitoring compliance to expectations, including on-going member and stakeholder feedback/engagement as well as numerous MCO-based activities.

The scope of the Quality Strategy is designed to incorporate the requirements outlined in the CMS Managed Care Regulation 42 CFR § 438.340. AHCCCS requires that the quality of health care and services it provides be transparent to its members, the community and its funders. AHCCCS has developed quality initiatives and strategies for evidence-based outcomes that:

- Reward quality of care, integrated service delivery, member safety and member satisfaction outcomes
- Support best practices in disease management and chronic care
- Provide feedback on quality and outcomes to MCOs and providers
- Provide comparative information to potential members, members, and stakeholders

The Agency's Quality Strategy is focused on continuous quality improvement based on the *"Triple Aim"* framework of healthcare. The Triple Aim was developed by the Institute for Health Improvement in 2007[1], and has been widely adopted by governmental and commercial organizations as a mechanism to improve both the member's healthcare experience and the system's performance simultaneously. In order to achieve the "Triple Aim", AHCCCS has formulated strategies that intend to simultaneously improve care, improve population health, and reduce costs. With these concepts in mind, AHCCCS has established the following quality goals and objectives:

Quality Goal 1: Improve the member's experience of care, including quality and satisfaction.

Objectives:

- Enrich member experience through an integrated approach to service delivery and improve information retrieval and reporting capability by establishing new and upgrading existing information technologies; thereby, increasing responsiveness and productivity.

[1] http://www.ihi.org/

- Enhance current performance measures, performance improvement projects and best practices activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs.
- Drive the improvement of member-centered outcomes, using not only nationally recognized protocols, standards of care and benchmarks; but also, the practice of collaborating with MCOs to reward providers based on clinical best practices and outcomes (as funding allows).

Quality Goal 2: Improve the health of AHCCCS populations

Objectives:

- Increase member access to integrated care that meets the member's individual needs within their local community.
- Support innovative reimbursement models, such as Alternative Payment Models, while promoting increased quality of care and services.
- Build upon prevention and health maintenance efforts through targeted medical management:
  - Emphasizing disease and chronic care management
  - Improving functionality in activities of daily living
  - Planning patient care for the special needs population
  - Identifying and sharing best practice
  - Expanding provider development of Centers of Excellence

Quality Goal 3: Reduce the growth in healthcare costs and lower costs per person

Objectives:

- Increase analytical capacity to make more informed clinical and policy making decisions.
- Develop collaborative strategies and initiatives with state agencies and other external partners, such as:
  - Strategic partnerships to improve access to health care services and affordable health care coverage
  - Partnerships with sister government agencies, MCOs and providers to educate Arizonans on health issues
  - Effective medical management of at-risk and vulnerable populations
  - Capacity building in rural and underserved areas to address both professional and paraprofessional shortages

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS. AHCCCS continues to collaborate with stakeholders to optimize both the experience and health outcomes of Arizonans accessing Medicaid Managed Care.

2.2 External Quality Review (EQR)

Over the past 35 years, AHCCCS has developed significant in-house resources, processes and expertise in monitoring its MCOs; as such, AHCCCS performs most of the External Quality Review (EQR) functions at the MCO-level, using an External Quality Review Organization (EQRO) to evaluate the work that AHCCCS completes against federal requirements. The EQRO is tasked with preparing an independent report that summarizes each AHCCCS MCO's compliance, strengths, weaknesses, implementation of corrective actions and identification of best practices and improvement opportunities. EQRO feedback is used to assess effectiveness of the current quality goals and strategies, and to provide a roadmap for considerations and potential changes to the Agency's Quality Strategy. This Quality Strategy is closely aligned and interfaces with the EQR report mandatory requirements defined in 42 CFR 438.364 and Section 401(c)(1) of CHIPRA which include: Review of MCO compliance with specified standards for quality program operations:

1. Validation of state-required performance measures
2. Validation of state required performance-improvement projects

AHCCCS regularly reviews its MCOs to ensure that their operations and performance are in compliance with Federal and State law, rules and regulations, and AHCCCS contract and policy. These Operational Reviews (ORs) provide information to the EQRO for its use in its annual report of AHCCCS and MCO compliance. External Quality Review Reports are posted on the AHCCCS website, and made available in accordance to 42 CFR 438.364.

a. EQRO process

Through the procurement process, AHCCCS ensures the qualifications of its CMS-required EQRO for both competence and independence as outlined in 42 CFR 438.354. This review provides an outside analysis and assessment of the MCO's performance and, as applicable, recommendations to improve MCO performance. The technical reports provide the following elements by line of business (e.g. Acute Care, ALTCS):

- An overview of the history of the AHCCCS program and a summary of AHCCCS' Quality Assessment and Performance Improvement (QAPI) strategy goals and objectives.
- A description of the EQR activities.
- An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those that are specific to each MCO.
- An overview of the MCOs' best and emerging practices.
- Organizational assessment and structure performance.
- Performance measure results and analysis.
- Performance improvement project results and analysis.[1]

b. Non-Duplication of Efforts

42 CFR 438.360 allows for the use of information from a Medicare or private accreditation review of an MCO to provide information for the annual External Quality Review instead of conducting one of more of the EQR activities. AHCCCS has elected to refrain from using this information at the current time.

2.3 Strategy Effectiveness

Data collection and analysis is utilized in the evaluation of the effectiveness of the strategies described in this Quality Strategy, in addition to other evaluation activities. Included within the analysis are trends and comparisons with established goals and benchmarks. Examples of these data include results of performance measures and performance improvement projects, as well as other data reported by MCOs, such as quality of care concerns.

The Quality Strategy is considered a companion document to the EQRO reports. As mentioned above, the EQRO reports encompass specific details of the assessment, results and recommendations related to the goals and strategies found in this document. This information is used to assess the effectiveness of the currently stated goals and strategies and provides a roadmap for potential changes and development of new goals/strategies. Strategy effectiveness, progress and updates are also reported in the AHCCCS Section 1115 Waiver Quarterly Report. This report describes AHCCCS Quality Assurance/Monitoring Activities during each quarter as well as summarized in the Agency's annual report to CMS, as required in the State's Section 1115 Waiver.

2.4 Frequent Strategy Evaluation

The Quality Strategy is reviewed at a minimum once every three years or as needed, based on significant program changes. Significant changes would include revisions to delivery system models, fundamental shifts in quality approaches, and/or changes that significantly impact the manner in which members receive care and services. The Quality Strategy review process includes an evaluation of the effectiveness of quality strategy efforts for the previous three years, or less, if conducting an earlier review. The results of the Quality Strategy reviews, and any updates or revisions are submitted to CMS for comment and feedback prior to adopting the changes. In addition, all updates and revisions are posted on the AHCCCS website and made available in accordance with 42 CFR 438.10 (c)(3) and 42 CFR 438.364.

3. Methods and Processes for Quality Development

Ensuring that the voice of the community is heard is very important to AHCCCS. Quality is a community process that is continuously informed and shaped by the voices and choices made by internal and external stakeholders. AHCCCS ensures agency transparency and community feedback into its Quality Strategy development through support of the following structures.

3.1 Public Information

AHCCCS employs a social media strategy to increase public access to information, generate positive public relations, interface with the media, support MCO community efforts, bolster Human Resources recruiting efforts, and gather information to increase business intelligence.

The AHCCCS Public Information Officer (PIO) is the messenger of information to the public and distributes public-facing information about the Agency's programs using press releases, website content, public and media relations, email newsletters, and social media. In addition, the PIO interfaces with external stakeholders including businesses, students, and AHCCCS members.

The AHCCCS blog profiles successful employees, health care initiatives, legislative updates, human interest stories about Medicaid members, and healthcare-related community events. Twitter posts at @AHCCCS.gov amplify external messages, support partner organizations, answer member questions, and drive traffic to the AHCCCS blog and website. LinkedIn posts promote agency business initiatives. To increase transparency and information sharing, AHCCCS divisions publish e-newsletters to which stakeholders and the public may subscribe.

3.2 Division of Health Care Advocacy and Advancement (DHCAA)

AHCCCS has a dedicated division that interfaces with members, peers, family members and other stakeholders receiving physical and behavioral health services in Arizona's Medicaid Managed Care delivery system. Dedicated teams within DHCAA include:

a. Human Rights Committees (HRC)

The Human Rights Committees (HRC) were created by the Arizona Legislature to assist AHCCCS and the Regional Behavioral Health Authorities (RBHAs), in promoting and protecting the rights of children and adults who receive publicly funded behavioral health services. The Committees provide independent oversight to ensure that rights of members are protected.

The HRCs are comprised of volunteers with an array of expertise including providers, members, family members, tribal representatives, advocates, mental health professionals and representatives from state agencies which review, monitor and evaluate the adequacy of behavioral health services in Arizona.

b. Office of Human Rights (OHR)

OHR is the State Advocacy Office established by the Arizona Administrative Code (A.A.C.), R9-21-104. An area of focus for OHR is direct advocacy to a population designated as Special Assistance. Special Assistance is a clinical designation that occurs when a member cannot participate effectively in his/her own treatment planning processes due to a condition. Currently in Arizona, there are over 2200 members that are receiving Special Assistance. The OHR also provides advocacy to individuals determined to have a Serious Mental Illness (SMI). Staff provides assistance to help members understand and learn how to protect and exercise their rights, facilitate self-advocacy through education and obtain access to behavioral health services within Arizona's publically funded system.

c. Office of Individual and Family Affairs (OIFA)

The Office of Individual and Family Affairs (OIFA) is staffed by peers and family members of persons receiving services in Arizona's behavioral health system. They bring their lived experiences to the forefront when making decisions that firmly incorporate recovery and resiliency into all aspects of service delivery. Moreover, OIFA:

- Builds partnerships with individuals, families of choice, youth, communities, organizations to promote recovery, resiliency and wellness
- Collaborates with key leadership and community members in the decision making process at all levels of the behavioral health system
- Advocates for the development of culturally inclusive environments that are welcoming to individuals, and families

- Establishes structures to promote diverse youth, family and individual voices in leadership positions throughout Arizona, deliver training, technical assistance and instructional materials for individuals and their families
- Ensures peer support and family support is available to all persons receiving services and their families and monitors MCO performance and measure outcomes

3.3 Arizona State Medicaid Advisory Committee (SMAC)

The State Medicaid Advisory Committee (SMAC) reviews and advises on the operations, programs, and planning for Arizona's Medicaid program. The SMAC advises the Director of AHCCCS on policy, operations and administrative issues of the Medicaid program, including issues of concern to the community. SMAC operates in accordance with 42 CFR 431.12 (Code of Federal Regulations) and the State Medicaid Plan. The bylaws for the committee were created in September 1992 and are reviewed annually, or on an as needed basis. SMAC is composed of a 17-member committee. Members are appointed for two-year terms. Appointments are made on a staggered basis with half the public and professional/provider members completing their terms annually.

3.4 Behavioral Health Planning Council

The Arizona Behavioral Health Planning Council is required by Public Law 103-321 to review Arizona's Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) Services Plans for Children and Adults. This review must occur before it is submitted to the United States Department of Health and Human Services (DHHS). The Council's membership is reflective of the diverse cultures in Arizona and is inclusive of behavioral health recipients, family members, advocates, state agencies and community providers. With exception for the months of June and August, the council and its committees meet on a monthly basis at locations throughout Arizona.

The Council is tasked with reviewing the MHBG and SABG plans provided by the State of Arizona and submitting to the State any Council recommendations for modifications to the plans. It also serves as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental health or emotional problems. The Council monitors, reviews and evaluates, not less than once each year, the allocation and adequacy of mental health services within the State.

3.5 ALTCS Advisory Council

The ALTCS Advisory Council consists of ALTCS members and their family members/representatives, ALTCS MCOs, providers, state and advocacy agencies and advocacy program representatives. The Council assists the ALTCS Program to develop a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS Members. Council Members advise on activities directed at system improvements. Individual Council Members provide input and feedback on ALTCS program activities from their own personal or professional experience, expertise and/or perspective.

3.6 Tribal Consultation

AHCCCS recognizes the unique government-to-government relationship that exists between Indian Tribes and Federal and State Governments. AHCCCS conducts Tribal Consultation on a quarterly basis to strengthen the special relationship between the Indian Tribes and the AHCCCS Administration and to ensure that reasonable notice and opportunity for consultation with Indian Tribes is provided by the AHCCCS Administration prior to implementing policy changes that are likely to have a direct effect on Indian Tribes which includes direct effects on one or more Indian Tribes, on the relationship between the State of Arizona and Indian Tribes, or on the distribution of power and responsibilities between the State of Arizona and Indian Tribes. AHCCCS has one designated Tribal Liaison who is responsible for Tribal Consultation and serves as the primary point of contact for tribal issues.

3.7 AHCCCS Community Quality Forum

This quarterly community forum focuses on bridging the gap between quality related and measurement efforts at all levels of the system. Participants include Quality Management staff from all MCOs, Tribal affiliates, consumers representing the community of members with serious mental illness, and mental health advocacy organizations such as National Alliance on Mental Illness (NAMI) and Mental Health America (MHA).

4. Population Management

4.1 State Procedures for Identifying Race, Ethnicity, and Primary Language of Each Member

AHCCCS receives member race and ethnicity and primary language information through the eligibility screening process, which collects the information at the time of application. This information, along with other demographics, is systematically updated on the AHCCCS member record file and transmitted daily to the MCO on the member enrollment roster. Changes to this information are also updated and transmitted to the MCO. MCOs are responsible for providing any updated information to AHCCCS that differs from the initial documentation provided for each member. AHCCCS updates the member information as appropriate. This information is included on the data exchange file received from the Social Security Administration. If any information is missing, the system will default to unknown or unspecified. If the member does not provide or does not wish to provide this information, he will be designated as unknown/unspecified.

Currently, there are codes for 40 languages that can be captured electronically. AHCCCS periodically assesses the language data to determine any need to expand the possible language categories. To date, the prevalent languages in the AHCCCS population are English and Spanish.

4.2 Population Management- Best Practices

AHCCCS has deemed several initiatives as best practices for populations served. These efforts show a committed focus to stakeholder engagement, system accountability, and reducing service fragmentation with the ultimate goal of improving member experiences and health outcomes.

4.3 Autism

On April 14, 2015, the Governor's Office established the statewide Autism Spectrum Disorder (ASD) Advisory Committee representing a broad range of stakeholders to address and provide recommendations to strengthen services for the treatment of (ASD. This committee has been instrumental in advising AHCCCS of appropriate system development and supports via first-hand experience in supporting children with ASD. The advocacy and partnership provided by this committee ensure strong stakeholder buy-in and feedback, as well as, informed decision-making and programmatic development. On February 9, 2016, the ASD Committee finalized its recommendations to strengthen Arizona's health care system to respond to the needs of AHCCCS members with, or at risk for, ASD. The recommendations include both long-term system-level changes, and short-term activities that will build on system capacity for access to care and stakeholder understanding of the needs for AHCCCS members with ASD. AHCCCS continues to host quarterly meeting with stakeholders.

AHCCCS accomplished the following:

- Successful registration of Board Certified Behavior Analyst (BCBA) as an independent, AHCCCS provider type.
- Determination of appropriate code set linkages to the BCBA Provider Type.
- Completed oversight to ensure the Regional Behavioral Health Authorities (RBHAs) have a web page identifying providers with specialization and expertise in ASD diagnosis.
- RBHA network expansion for Children's Rehabilitative Services (CRS) and RBHA MCOs.
- Clinical and operational determination made to maintain ASD services under the behavioral health system (as opposed to physical health) until October 1, 2018, when Arizona's integrated model will be fully operational.
- For continued improvement to the service delivery system and implementation of recommendations from the ASD Advisory Committee, AHCCCS holds bi-monthly operational team meetings. AHCCCS will continue to develop policy, conduct a network analysis, and continue monitoring utilization of members at risk and diagnosed with ASD.

4.4 Integrated Health Care

One of the primary goals of AHCCCS is to reduce system fragmentation and develop systems of care that are easy for members to navigate. Over the next two years, Arizona is looking to fully integrate all delivery systems, with the vast majority of members moving into integrated plans on October 1, 2018, with the implementation of the AHCCCS Complete Care contract.

a. AHCCCS Complete Care

The AHCCCS Complete Care Program will be implemented October 1, 2018 through MCOs that will ensure the delivery of integrated physical and behavioral health services to address whole health needs of AHCCCS members and to improve the member experience. The MCOs are expected to continuously add value to the program by exhibiting the following:

I. Recognition of the importance of an integrated delivery system for physical and behavioral health services and demonstrates focused strategies and approaches to assure coordinated service delivery to members,

II. Recognition and demonstration of the critical importance of care coordination through organizational design and operational processes,

III. Recognition that Medicaid members are entitled to care and assistance navigating the service delivery system and demonstrates special effort throughout its operations to assure members receive necessary services,

IV. Recognition that Medicaid members with special health care needs or chronic health conditions require care coordination, and provides that coordination,

V. Recognition that health care providers are an essential partner in the delivery of physical and behavioral health care services, and operates the Health Plan in a manner that is efficient and effective for health care providers as well as the Contractor,

VI. Recognition that performance improvement is both clinical and operational in nature and self-monitors and self-corrects as necessary to improve Contract compliance and/or operational excellence,

VII. Recognition that the program is publicly funded, is subject to public scrutiny, and operates in a manner that promotes cost containment and efficiency, and

VIII. Recognition of the importance of the System Values and Guiding Principles.

b. ALTCS

Since its inception in 1989, the ALTCS Elderly and Physically Disabled (E/PD) program has been a fully integrated product. E/PD members receive all services through their MCOs and many are aligned to receive their Medicare benefits through the MCO's D-SNP plan, which allows for enhanced care coordination.

c. Members Living with an SMI

Members who are in the Acute Care program and have been determined to have a Serious Mental Illness (SMI) receive all of their acute care and behavioral health services through a RBHA MCO. Members determined to have a SMI and residing in Maricopa County (central region) began receiving integrated care on April 1, 2014. Integration efforts expanded to Northern and Southern regions on October 1, 2015, transitioning all SMI-determined members into an integrated delivery system.

d. Medicare and Medicaid Dual Eligible Members

As of October 1, 2015, dual eligible members (eligible for both Medicaid and Medicare) in the Acute Care program began receiving behavioral health services from their enrolled Acute Care MCO. In addition to integration of Medicaid services, AHCCCS has promoted extensive alignment efforts between Medicaid and Medicare. As of May 2018, 46 percent of dually-enrolled members are in aligned plans. This includes members enrolled in the American Indian Health Plan (AIHP).

e. American Indian Medical Home (AIHM)

Arizona is home to over 350,000 American Indians/Alaska Natives (AI/AN), approximately half of whom are enrolled in AHCCCS. Significant health disparities exist for the AI/AN population.

For instance, the average age of death for American Indians is 17.5 years younger than the general population, and American Indians experience higher death rates from preventable diseases. Whereas the American Indian population accounts for less than 2% of the national population and 4% of the Arizona population, it accounts for approximately 10% of the AHCCCS population. Recognizing its unique role in addressing the health needs of Arizona's AI/AN population, AHCCCS has launched a new effort to improve the health outcomes of tribal members by identifying critical population needs and collaborating with tribes, tribal health partners, community organizations and state and federal agencies to enhance care coordination.[2]

To that end CMS, has approved Arizona's State Plan Amendment for the American Indian Medical Home (AIMH) Program for the AI/AN members enrolled in the American Indian Health Program (AIHP). The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for AIHP enrolled members. AIMHs help address health disparities between American Indians and other populations in Arizona by enhancing case management and care coordination. The AIMH PCCM program is a voluntary program. Individuals who elect to participate in the AHCCCS Fee-For-Service (FFS) AIHP can select a participating AIMH site. AIHP enrolled members can select an AIMH when they access a participating AIMH provider or by contacting AHCCCS. Selection forms are available at AIMH sites and on the AHCCCS website and are processed by AHCCCS on a monthly basis. Forms are available both electronically and paper formats. The form identifies benefits of the program, the right to disenroll or select a different AIMH provider at any time, and any other information required by federal and state regulations including 438.54(c)(3).

4.5 Long Term Care Supports and Services

a. Long Term Care Case Management

Each ALTCS-enrolled member receives case management services provided by a qualified Case Manager. ALTCS Case Managers utilize a person-centered approach and maximize member/family self-determination while promoting the values of dignity, independence, individuality, privacy and choice. Case Managers conduct regular on-site, face-to-face visits with members to ensure quality services are being provided without gaps; to determine the services necessary to meet the member's needs, to provide member specific education to the member and their family, and to introduce alternative models of care delivery when appropriate. The reviews conducted by the case managers should result in a mutually agreed upon, appropriate and cost effective individualized service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated and least restrictive setting. The following are examples of how Case Managers execute their above-mentioned roles and responsibilities:

- Member-Directed Options Information: Case Managers regularly inform members about member-directed options and assist members and their families to make informed decisions about the service delivery model of care.
- Cost Effectiveness Analysis: Case Managers assess the continued suitability, appropriateness, and cost effectiveness of the member's in-home services. HCBS placement is the goal for ALTCS members as long as cost effectiveness standards and the

[2] https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/

member's medical, functional, social and behavioral health needs can be met in that setting. The Case Manager regularly assesses the cost of the HCBS services and compares them to the estimated cost of institutionalized care. Placement in an HCBS setting is considered cost effective if the cost of HCBS services for a specific member does not exceed 100 percent of the net cost of institutional care for that member.

- Non-Medicaid Service Coordination: Case Managers identify and integrate non-ALTCS covered community resources/services as appropriate, based on the member's needs. Case Managers are also responsible for assisting members in identifying independent living/personal goals while also providing them with information about local resources that may help transition them to greater self-sufficiency in the areas of housing, education, employment, recreation and socialization.

Effective October 1, 2017, within the AHCCCS ALTCS Elderly/Physically Disabled (EDP) Contract, two new requirements were added:

- End of Life Care: Case Managers are required to educate members/family on End of Life Care which encompasses all health care and support services provided at any age or stage of an illness. End of Life Care goals focus on comfort and quality of life. Services include Advance Care Planning, palliative care, supportive care and hospice.
- Person Centered Service Planning for person determined to have a Serious Mental Illness (SMI): In an effort to enhance the person-centered approach and further maximize member/family self-determination, AHCCCS initiated a process to:
    - Create alignment of practices, forms and monitoring of person-centered service planning (PCP) approach and personal goal development
    - Support members to have the information and supports to maximize member-direction and determination
    - Develop processes to document health and safety risks and safeguard against unjustified restrictions of member rights in accordance with the Home and Community Based Settings rules

In August 2016, AHCCCS entered into an Interagency Service Agreement with the Sonoran University Center of Excellence in Developmental Disabilities (UCEDD) at the University of Arizona, a recognized organization with subject matter expertise in the arena of person-centered service planning. Beginning in mid-September, the Sonoran UCEDD and AHCCCS will begin facilitating an HCBS Person Centered Service Planning Advisory Workgroup. This will be a multi-stakeholder workgroup comprised of ALTCS members, their families, providers, advisory groups, and Managed Care Organizations/Tribal Contractors. Throughout the process, the workgroup will provide input, on any policies, forms, and trainings that are created, in order to transition to a more uniform person centered service planning process.

b. Testing Experience and Functional Tools (TEFT) Grant

The demonstration grant for Testing Experience and Functional Assessment Tools (TEFT) in Home and Community Based Services Long-Term Services and Supports (LTSS) is designed to test quality measurement tools and demonstrate e-health in Medicaid long term care services and supports. The TEFT grant funding was awarded on April 1, 2014, and will conclude on March 31, 2019. Year 1 was designated to develop work plans outlining all grant components, which

mapped implementation for Years 2-4. The purpose of the TEFT grant is to support States in furthering adult quality measurement activities under section 2701 of the Patient Protection and Affordable Care Act. The TEFT grant advances the development of two national, rigorously tested tools that can be used across all beneficiaries using HCBS, an area in need of national measures. Additionally, the grant offers funding and technical support to demonstrate the use of a Personal Health Record (PHR) and test new electronic standards for interoperability among long term services and supports data.

Arizona has selected both ALTCS populations (individuals who are elderly, have physical and/or intellectual disabilities) to participate in the HCBS Consumer Assessment of Health Care Providers Survey (CAHPS) Experience of Care survey and the testing of the Functional Assessment Standardized Items (FASI) tool. During Year Two, Arizona received results from the Round One Experience of Care Survey and in Year 2 completed Round One testing of the FASI tool. In regards to the FASI, training and assessments were completed in July of 2017. Round Two of the HCBS CAHPS survey and the FASI Tool are scheduled to be completed in late summer 2018with analysis and results to be released in late 2018.

c. HCBS Rules

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released final Rules regarding requirements for home and community based services (HCBS) operated under section 1915 of the Social Security Act[1]. The Rules mandate certain requirements for residential and non-residential settings where Medicaid members receive long term care services and supports. Specifically, the Rules establish requirements for settings to ensure that individuals receiving services are integrated into their communities and have full access to the benefits of community living. In Arizona, these requirements impact ALTCS program members receiving services in the following residential and non-residential settings:

- Residential
- Assisted Living Facilities
- Group Homes
- Adult and Child Development Homes
- Behavioral Health Residential Facilities

Non-Residential

- Adult Day Health Programs
- Day Treatment and Training Programs
- Center-Based Employment Programs
- Group-Supported Employment Program

Between November 2014 and May 2015, AHCCCS conducted a systemic assessment of Arizona's HCBS settings to determine current level of compliance, provide recommendations for identified variances, and outline a process for continuous monitoring. The systemic assessment process included a review of Arizona Revised Statutes, Arizona Administrative Code (licensing Rules) and AHCCCS and MCO policies and contracts.

AHCCCS engaged various stakeholders in the assessment process and in the development of the transition plan. The purpose of these meetings was to dialogue with, and solicit input from stakeholders regarding the preliminary assessment findings and draft recommendations to ensure

compliance with the HCBS Rules. AHCCCS made revisions to the Assessment and Transition Plan based upon the input received. The meetings also served as an orientation for stakeholders and a strategy to support stakeholders in providing informed public comment during August 2015. Following the stakeholder meetings, AHCCCS enacted an official public comment period from August 1 - 31, 2015, which included eight public forums hosted by AHCCCS throughout the state. AHCCCS published the draft Systemic Assessment of Arizona's HCBS settings and the draft Transition Plan for bringing the settings into compliance. After review and consideration of all public comment, AHCCCS finalized the assessment and transition plan and submitted to CMS for approval in October 2015.

Consistent with AHCCCS' ongoing efforts to be transparent and accountable to the general public during the implementation of the Transition Plan, AHCCCS will post reports on the website (www.azahcccs.gov/hcbs) to delineate progress with quarterly and annualized milestones. AHCCCS will continue to solicit, receive and incorporate public input regarding progress made on Transition Plan implementation.

AHCCCS will continue to periodically disseminate member surveys to systematically capture the member experience at the ALTCS program macro level. The HCBS Rules will be used as the standard for measurement. With respect to individual member experiences, the Case Manager will play a critical role in assessing and addressing barriers to members accessing community living benefits. Questions will be developed for inclusion in the Case Manager's review of the person centered plan to ascertain member experience and feedback regarding provider compliance with the HCBS Rules requirements. MCOs will also assess the member experience through member interviews conducted as a part of annual quality and contract monitoring of the settings noted above.

d. Electronic Visit Verification (EVV)

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS is mandated to implement Electronic Visit Verification (EVV) for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite) by January 1, 2019, and for in-home skilled nursing services (home health) by January 1, 2023. The EVV system, must at a minimum, electronically verify the:

- Type of service preformed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

AHCCCS' goals for instituting EVV include:

- Ensuring timely service delivery for members including real time service gap reporting and monitoring
- Reducing administrative burden associated with hard copy timesheet processing by AHCCCS providers
- Generating cost savings from the prevention of fraud, waste and abuse

AHCCCS is employing a number of strategies/activities to ensure the EVV system meets both federally mandated and AHCCCS requirements. In order to make an informed decision on the EVV system requirements, AHCCCS has formed a multi-disciplinary Steering Committee comprised of internal and external parties (members, providers, Managed Care Organizations, etc.). Additionally, AHCCCS has engaged stakeholders to provide public comment. In-person forums will be facilitated for members and their families while providers will simultaneously have an opportunity to submit public comment through a Request for Information process. Once a system is procured and awarded, AHCCCS will continue to solicit input from the Steering Committee to ensure a successful orientation and transition to the new EVV system by members, families, Direct Care Workers, providers and MCOs.

4.6 Centers of Excellence

Starting October 1, 2015, AHCCCS required all contracted MCOs to develop approaches for identifying Centers of Excellence. The Centers are facilities that are recognized as providing highest levels of leadership, quality and service. They align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Designation as a Center of Excellence is based on criteria, such as procedure volumes, clinical outcomes, treatment planning and coordination. Each MCO was required to submit a report identifying why it selected a procedure or condition, how it identified and selected providers to address them, how it will drive utilization to the providers, and any barriers or challenges in the development of the Centers of Excellence.

The following year, MCOs were required to submit an update on their progress in identifying and implementing the Centers. They submitted their goals and outcome measures for the Centers, their monitoring activities, an evaluation of the effectiveness of the previous year's initiatives, and a plan for the coming year. In July 2017, by act of the State Legislature, AHCCCS became the direct administrator of managed care contracts for State funded and Medicaid behavioral health services (RBHAs). As a result, these contracts also include a requirement to develop similar Centers of Excellence programs.

MCOs have employed a variety of approaches in developing their Centers of Excellence. For example, one MCO identified an existing provider that excelled in offering skilled nursing care services. Their goal is to utilize this provider for members with more acute physical needs, but not yet long term care needs. The provider offers strong family integration services and on-site services for dialysis, blood transfusions and other services that limit the need for burdensome transportation. Not only has this provider demonstrated improved quality of care, but members assigned to this provider have also had lower than average readmission and outpatient ED visits than other providers within the state. Finally, the MCO's financial analysis indicated this provider's utilization costs were not excessively higher than other comparable providers.

Another MCO issued an RFI to establish an ASD Center of Excellence. The MCO will fund an integrated care clinic for individuals with ASD that provides medical, behavioral and psychosocial services and care coordination based on evidence-based treatment modalities and practices for serving individuals with Autism and their families. Following best practice models will allow members and families to receive care from the best providers, in addition to care coordination and multidisciplinary evaluations and treatment.

AHCCCS continues to improve its Centers of Excellence program. Starting in 2017, rather than submitting a separate update to their Centers of Excellence Program, AHCCCS required the MCOs to incorporate their program updates with their Annual Network Development and Management Plan. It is AHCCCS' intent that these programs be integrated into the context of each MCO's overall network strategy.

4.7 Residential Facilities and Oversight

AHCCCS monitors residential facilities in a variety of ways. One way is to provide oversight of MCO adherence to network standard requirements, as outlined in the AHCCCS Contractor Operations Manual (ACOM 436, Network Standards). Another way is to ensure a general assessment of network adequacy for member service needs. AHCCCS also closely evaluates monitoring of treatment settings for clinical and quality performance. AHCCCS issues requests to MCOs with specific requirements for auditing and reporting. A recent example of this occurred when AHCCCS required an audit of various Behavioral Health Residential Facilities (BHRFs), which assessed services, treatment plans, and other facets of care. The goal was to identify the scope of services within each BHRF setting and to address any improvement opportunities that may have been observed during the audit.

AHCCCS has both an Office of Human Rights and Office of Individual Family Affairs that engage with community members on an ongoing basis. It is through this work that many system concerns are identified. To further enhance monitoring efforts, AHCCCS collaborates with the Arizona Department of Health Services (ADHS) for those facilities licensed by ADHS.

4.8 Prevention Efforts and Attention to the Overuse of Opioids

The toll of the opioid epidemic has swept the nation. Arizona, like most states in the country, has witnessed the rising tide of opioid-related deaths. In 2016, more than two Arizonans died each day due to opioid-related causes, with a tripling in the number of deaths due to heroin since 2012. In an effort to combat the opioid epidemic, AHCCCS developed an Opioid Strategic Plan in 2016, and has been implementing three major strategies together with MCOs, providers, and community champions across several impacted sectors. The overarching goals of the AHCCCS Opioid Initiative are as follows:

1. Enhance harm reduction strategies to prevent overdose
2. Enhance Access to Medication Assisted Treatment (MAT) for individuals with Opioid Use Disorder (OUD)
3. Promote responsible prescribing and dispensing policies and practices

The implementation plan includes a blend of objectives designed to increase coordinated and integrated care, recovery support services and prevention activities to reduce the prevalence of OUDs and opioid-related overdose deaths. The project approach includes developing and supporting state, regional, and local level collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse and dependency.

Strategies to Combat Opioid Abuse

- **Increase access to Naloxone**: Conduct community-based education and naloxone distribution; encourage co-prescribing of Naloxone for all members prescribed greater

than 90 Morphine Equivalent Daily Doses and for any situations involving combinations of opioids and benzodiazepines.

- **Increase access, participation and retention in MAT**: Increase provider capacity among Opioid Treatment Programs, Office Based Opioid Treatment providers and Residential settings that allow all three forms of Medication Assisted Treatment; Increase 24/7 access to care sites through Opioid Treatment Centers of Excellence; Increase navigation to treatment and retention in treatment through expansion of peer supports and care coordinators; Increase ability to identify and navigate justice-involved individuals and pregnant and parenting women to Medication Assisted Treatment.

- **Promote responsible prescribing and dispensing policies and practices**: Reduce the number of opioid-naïve members unnecessarily started on opioid treatment by limiting first opioid fills for first acute episodes to no more than 5 days; promoting the Arizona Opioid Prescribing Guidelines and opioid prescribing education; non-opioid best practices for effective pain management; use of mental health, trauma and substance use screenings prior to prescribing opioids; and opioid risk education materials for members; Improve care processes for chronic pain and high-risk members by using data to identify problematic prescribing patterns and coordinating provider education; Using data to identify high-risk members and coordinating to appropriate care; use of the Controlled Substance Prescription Monitoring Program; Promote e-prescribing of controlled substances; Increase access to non-opioid methods for managing chronic pain; Incentivize Centers of Excellence for integrated behavioral health and pain management; increase options for complex case consults.

4.9 Foster Care Youth

AHCCCS is committed to providing comprehensive, quality health care for children in foster/kinship/adoptive care. Foster children are eligible for medical and dental care, behavioral health, and other services through CMDP and the RBHAs or through CRS, depending on presence of CRS qualifying diagnosis. Adoptive children are typically AHCCCS eligible and are enrolled into an MCO/RBHA or CRS similar to any Medicaid eligible child.

AHCCCS holds a variety of meetings related to improving service delivery for children in foster care. There are monthly collaborative meetings with Department of Child Safety and with CMDP staff to continue efforts to improve service delivery for children in the foster care system and ensure availability of medically necessary services. AHCCCS hosts monthly cross-divisional operational team meetings to continue efforts and quarterly meetings with RBHA and CRS leadership to review data and discuss system changes and best practices. System improvements include frequently asked questions document and behavioral health and crisis services flyers for foster and kinship caregivers, as well as, streamlining MCO deliverables. AHCCCS created a dashboard to track and trend utilization for children in foster care. This dashboard report is posted to the AHCCCS website. Furthermore, AHCCCS hired Mercer Government Human Services Consulting (Mercer) to perform an analysis of implementing an integrated health plan for children in foster care. The analysis was designed to identify the necessary operational and ongoing infrastructure requirements of an integrated health plan administered through the Arizona DCS/CMDP.

Jacob's Law

House Bill 2421, also known as Jacob's Law, was signed into law by Governor Ducey on March 24, 2016. The legislation was introduced by community advocates and establishes specific requirements related to resources, supports, coordination, and the timely provision of behavioral health services for children involved with DCS and in foster, kinship and group home settings, in addition to children in adoptive homes. It also stipulates reporting requirements related to the delivery of behavioral health services for timeliness and sufficiency.

AHCCCS developed ACOM Policy 449: Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children, in order to implement legislative requirements. Additionally, AHCCCS created a web page with helpful information and resources to support the families, community and providers involved in the care and treatment of foster and adoptive children. Jacob's Law mandates the following:

- Designated points of contact for the Regional Behavioral Health Authorities (RBHAs) and AHCCCS.
- The RBHA must dispatch an assessment team within 72 hours after being notified that a child has been placed out of their home.
- The RBHA must dispatch an assessment team within 2 hours as indicated in the event of a crisis or urgent need.
- An initial evaluation of the child must be completed within 7 calendar days after a referral or request for services.
- An initial behavioral health appointment must be provided within 21 calendar days after the initial evaluation.

In the event the initial behavioral health appointment is not provided within 21 calendar days, the out of home placement or adoptive parent must notify the RBHA and AHCCCS, and may access the service directly from any AHCCCS registered provider regardless of whether or not the provider is contracted with the RBHA. The RBHA must respond to a request for a foster or an adopted child to be placed in residential placement due threatening behavior within 72 hours. If a foster child is moved to a different county he/she may continue to receive treatment in the previous county or seek treatment in the new county.

4.10 Justice Population

Approximately 120,000 individuals are released from Arizona jails and prisons each year. Over 70 percent of inmates have a diagnosed mental health and/or substance use disorder. The volume of complex needs within this population make it difficult to provide high-touch care to all who need it. However, despite the challenges, AHCCCS is actively engaged with the Arizona Department of Corrections (ADOC) and most of Arizona's counties, including Maricopa and Pima, in a data exchange process that suspends AHCCCS enrollment upon incarceration, instead of terminating coverage. This exchange allows ADOC and counties to electronically send discharge dates for AHCCCS members, which simplifies the process of transitioning members directly into care. Through this enrollment suspension process, care can be coordinated by county jails or prisons upon discharge for over 95% of members involved in Arizona's criminal justice system. Additionally, AHCCCS MCOs are required to provide **"reach-in"** care coordination to identify members with complex health needs prior to their release from incarceration. MCOs, including the RBHAs connect case managers to members pre-release to

provide information and schedule appointments with primary care physicians and behavioral health providers, as appropriate.

AHCCCS has intergovernmental agreements implemented with the majority of counties in Arizona (including Maricopa and Pima) and ADOC to provide services to people in detention who are admitted temporarily into an inpatient hospital setting. This process includes a determination of eligibility for AHCCCS. When a detainee is released from custody temporarily to an inpatient hospital setting, designated staff assists the individual with completing an application for AHCCCS coverage. The application is submitted to a special unit that determines AHCCCS eligibility for the specific period of the hospital stay. When the detainee is determined eligible, the hospital will submit a bill to AHCCCS to pay for the brief hospital stay.

ADOC and multiple Arizona counties (including Maricopa, Pima and Navajo) submit pre-release applications via HEAplus (AHCCCS eligibility system) for AHCCCS approximately 30 days before detainees are released from incarceration. If additional information is required, these applications are submitted to special units at AHCCCS and the Department of Economic Security (DES) for review and processing assist. Staff in these special units reviews the applications for eligibility and approvals become effective when the applicant is released from custody. Submission of applications prior to release helps to ensure that individuals who need critical care are enrolled in AHCCCS immediately upon their release. Those, who are at risk of needing an institutional level of care upon their release receive a pre-admission screening while incarcerated and have a Medicaid application completed. When eligible, the member is connected to ALTCS and placed into a long-term care setting immediately upon their release.

4.11 Suicide Prevention in Arizona

Suicide is one of the leading causes of death nationally. In 2016, 1310 Arizonans died by suicide. The average age was 49.5. The majority of these deaths were by gun. AHCCCS publishes an annual suicide prevention plan[3] highlighting populations at risk and community partnerships. AHCCCS works with the Arizona Coalition to Prevent Suicide to disseminate information regarding suicide prevention. Additionally, the RBHAs include suicide prevention in their Substance Abuse and Suicide prevention planning. All MCOs are required to address suicide prevention in their policies and to provide suicide prevention training to their front-line staff. In SFY 19 AHCCCS, will add the position of Suicide Prevention Coordinator to the Office of the Director reporting to the Chief Medical Officer to oversee State suicide prevention efforts.

4.12 System of Care/Grants

The System of Care and Grants Unit within DHCM has applied for and been awarded several key grants that help achieve the Agency's Mission and Vision for individuals who are either under or uninsured. The federal grants received by AHCCCS have a narrowly defined purpose for which the state has demonstrated a need. The current grants focus on: Substance Use Disorders; Mental Health, Homelessness, Medication Assisted Treatment (MAT) and Opioid Use Disorder, including prevention and treatment for both adolescents and adults.

[3] https://www.azahcccs.gov/AHCCCS/Downloads/Plans/2016AZSuicidePreventionPlan.pdf

4.13 Housing

In Arizona, supportive housing services are included under the AHCCCS Behavioral Health Covered Service Guide[iii]. These services are provided to help a member stay housed in a stable environment. Additionally, there is state funded annual allocation for housing subsidies, which can be utilized for both individuals diagnosed with a serious mental illness (SMI), as well as, those diagnosed with a general mental health/substance abuse (GMHSA) disorder. AHCCCS has an annual budget of $26 million for housing services and subsidies. The majority of subsidies are allocated to individuals living in Maricopa County and diagnosed with a serious mental illness. These subsidies are a result of the 2014 *Arnold v. Sarn* exit agreement[iv], which expanded permanent supportive housing (service and/or subsidy) to more than 750 members in the county. Additionally, the Arizona State Legislature allocates $2 million annually to an SMI Housing Trust Fund. With these dollars, RBHAs can purchase and renovate properties (with some limitations) for individuals with a SMI. Properties purchased or renovated with these dollars are limited to the use of those individuals diagnosed with an SMI through Covenants, Conditions, and Restrictions (CC&Rs) for a period of time ranging from 15-30 years.

Statewide, Arizona is facing an affordable housing crisis[v]. Arizona's dramatically increasing population (220 people per day to Maricopa county alone), coupled with a strong jobs market, has left rental vacancies at historic lows. Some cities report less than a 3% vacancy rate. This is more complicated in Arizona's rural communities. AHCCCS works closely with RBHAs, ALTCS providers and the MCOs, to ensure adherence to following national best practices regarding assessment and placement of homeless individuals. MCOs are required to use the Vulnerability Index Service Prioritization Decision Assistance Tool[vi] (VI-SPDAT) to assess a member's housing needs, and rank members accordingly on a housing wait list. Housing staff are expected to be familiar with the Housing Quality Standard (HQS) inspections process[vii] to make sure members are being housed in safe environments. RBHAs work closely with landlords and with developers, to ensure available housing units are matched with members. Once matched, the member is provided supportive services to help keep him/her successfully housed. For chronically homeless individuals, the first 30 days are critical for supportive services to prevent eviction. RHBAs work with other community housing providers when possible. For example, one RBHA recently partnered with a city housing program to transition 25 individuals with an SMI to Section 8 vouchers.

In the future, AHCCCS will have county listings of members' housing needs, regardless of their assigned MCO. This may be determined by the point-in-time homeless count, census data, and interviewing members. Additionally, AHCCCS will continue to work on the quality of services provided by standardizing programmatic language and reporting, implementing the permanent supportive housing fidelity review statewide, strengthening relationships with homeless outreach teams, and encouraging developers to keep the Medicaid and vulnerable populations in mind when developing new properties.

4.14 Workforce Development

Workforce Development (WFD) is action planning to strategize and implement plans to ensure the development, deployment and retention of a qualified and capable workforce. WFD also includes human resource management technologies (i.e. workforce analysis, forecasting, planning, and monitoring). The responsibility for ensuring members receive AHCCCS covered

services from licensed and unlicensed, but appropriately trained healthcare professionals, is a collaborative process shared by the three types of organizations:

- Providers - directly acquire, develop, deploy and retain a qualified and capable workforce.
- MCO - plan, monitor and ensure providers are maintaining a qualified workforce with sufficient capacity, capability and access to the training and development resources needed to perform the their jobs.
- AHCCCS - analyzes current and future healthcare workforce trends, forecasts and describes workforce requirements and generates policies for managing the development and deployment of the healthcare workforce.

Monitoring the activities and intended accomplishments described in the Annual WFD Plan is the primary way AHCCCS evaluates the productivity and success of MCOs' WFD programs. Workforce development directly affects the health care that members receive, as well as, the health outcomes they experience. Services must be provided by a sufficiently skilled workforce who is capable of meeting member needs in the most interpersonally, clinically and culturally appropriate manner possible. AHCCCS, the MCOs, leaders from the provider community and industry groups are working collaboratively to strategize, develop measures and methods for analyzing the needs, and action planning for how to attract and retain the desired workforce. Specifically, AHCCCS is working towards:

- Increasing its capacity to collect workforce data, analyze workforce trends, facilitate workforce planning and mobilize the human, educational and community resources needed to both attract and prepare qualified workers to deliver contracted services.
- Enabling MCOs to better assist providers enhance their WFD programs by providing both direct and indirect technical assistance on an as needed.
- Developing partnerships with communities, industry group and educational resources to develop regional approaches to recruiting talented individuals, including current AHCCCS Members, to join the integrated healthcare workforce, preventing, reducing or eliminating health professional shortages in key areas and in general improving the efficacy of the state's education, training and development programs.

4.15 Employment Support

AHCCCS believes that every person is capable of working competitively in the community when the right kind of job and work environment is found. Competitive employment means community-integrated employment with wages and benefits equal to that of anyone doing the same job. Employment is not solely about a paycheck.

The RBHAs and ALTCS/EPD MCOs are required to maintain subcontracted arrangements with at least one fully dedicated employment/rehabilitation provider staff at each clinic whose only duties are to include employment and rehabilitation-related activities. (i.e. employment, meaningful community involvement activities). AHCCCS tracks the utilization of covered services from the RBHAs as part of their quarterly deliverables.

For individuals determined to have a SMI, AHCCCS and the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA), which includes the state

Vocational Rehabilitation (VR) program, have an established Interagency Service Agreement (ISA) to provide specialty employment services. AHCCCS funds approximately $3.1 million for this agreement that RSA uses as state match to draw down additional federal monies. The overall funding is used toward client services, staffing, and training. VR submits quarterly deliverables that include client progress statuses and staffing capacity. Some of the special requirements within the ISA are:

- Vocational Rehabilitation (V/R) counselors have specialized caseloads consisting of individuals with psychiatric disabilities. V/R counselors are cross-trained in the area of psychiatric disabilities to effectively serve the individual needs of the clients.
- The federally mandated, 60-day eligibility requirement for VR applicants is modified to 30-days; VR Counselors and RBHA provider employment staff has weekly consultations regarding the progress of mutual program participants. An annual assessment is performed by the RBHAs to demonstrate the collaborative partnership.
- The ISA also requires bi-annual ISA Advisory Committee meetings and bi-annual regional coordination meetings to occur for collaboration with all stakeholders in efforts to enhance program delivery methods in order to increase successful employment outcomes. The AHCCCS contract with the RBHA mandates their adherence to the ISA.

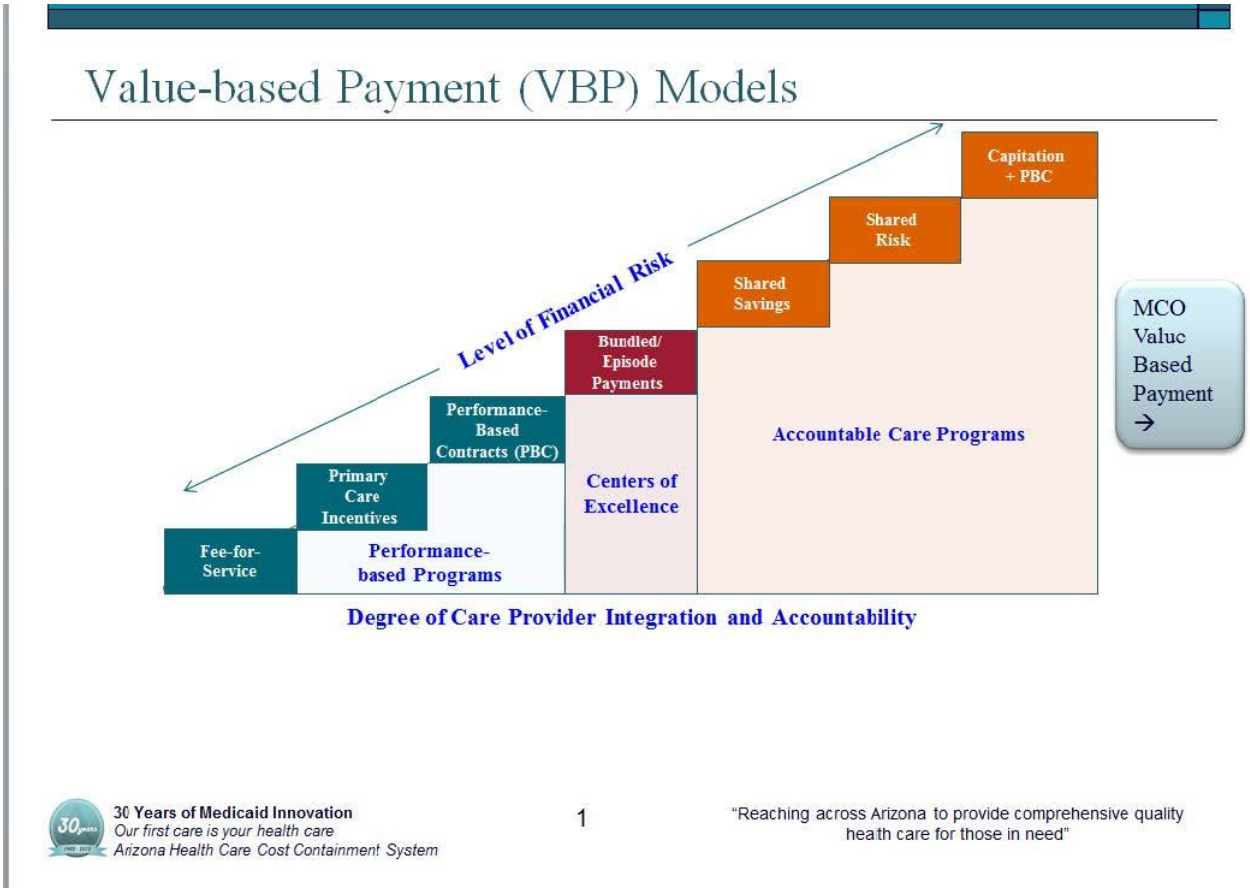
AHCCCS is expanding employment requirements beyond the RBHAs, by including employment requirements for MCOs more generally. AHCCCS is educating MCOs on the usage of Medicaid covered employment services. For the ALTCS contract, the ALTCS plans are required to employ staff designated as the subject matter expert on employment and employment services. Their role is to assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options, including employment. Deliverables have been attached to the ALTCS contract (effective October 1, 2017) related to Employment. For AHCCCS Complete Care (ACC) (effective October 1, 2018) the integrated MCOs will be required to maintain subcontracted arrangements with at least one fully dedicated employment/rehabilitation provider staff at each clinic whose only duties are to include employment and rehabilitation-related activities. Deliverables will be attached to the ACC Contract around Employment.

AHCCCS has also begun efforts to help transform the employment system by coming into compliance with the Centers for Medicare & Medicaid Services' (CMS) Home and Community Based Service (HCBS) rules[viii] specific to employment services (Center-Based Employment and Group Supported Employment). The purpose of the rule is to ensure that individuals receiving HCBS are integrated into their communities and have full access to the benefits of community living, including employment settings. By March 2022, through the help of a workgroup facilitated by the AHCCCS Employment Administrator, Arizona will need to be compliant, so that all members have the opportunity to seek competitive employment in the most integrated setting and to the same degree of access as individuals not receiving HCBS.

5. Provider Payment Strategies

AHCCCS is pursuing the implementation of long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value based health care systems where members' experience and population

health are improved, per-capita health care costs are limited to the rate of general inflation through aligned incentives with MCO and provider partners, and there is a commitment to continuous quality improvement and learning. Refer to the graphic display of the long term strategy AHCCCS employs for Value-based Payment (VBP) Models below.



Today's reimbursement structure favors the provider with higher production numbers, (i.e. performs more services without regard to outcome). In order to bend the cost curve, there must be a paradigm shift such that reimbursement favors the provider who achieves quality health outcomes. That is why payment modernization is a critical policy strategy for moving to a financially sustainable and value-based healthcare delivery system.

Strategies AHCCCS employs to move care delivery and payment to value based healthcare include:

- Aligning Payer & Provider Incentives: Establish payment systems that encourage collaboration to improve affordability, access and quality results for individuals
- Payment and Care Delivery Transformation: Transform the health care delivery system and achieve the three-part aim outlined by the Institute of Medicine (IOM): better care, healthy people/healthy communities, and affordable care.
- Innovate through Competition: Enact performance expectations that reward innovation and results.

5.1 Pay for Value

Paying for value means to reimburse for better outcomes of care rather than quantity of care. AHCCCS is a committed partner in the Health Care Payment Learning and Action Network (LAN). The goal of the LAN is to accelerate the health care system's adoption of effective alternative payment models (APMs). The LAN also has a compendium of APM resources for health care providers and payers. Below are examples of APMs that have been implemented by AHCCCS MCOs within their provider networks:

- Payment for Performance - is a term that describes health- care payment systems that offer financial rewards to providers who achieve, improve, or exceed their performance on specified quality and cost measures, as well as other benchmarks.
- Patient-Centered Medical Home (PCMH) - is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into *"what patients want it to be."*
- Shared Savings - Shared savings models have a baseline budget or target that is used to determine whether savings were achieved. Savings which result are shared between the payer and the provider. Quality measures are usually part of the shared savings methodology.
- Bundled Payment – is a single, "bundled" payment covers services delivered by two or more providers during a single episode of care or over a specific period of time, and usually includes accompanying quality requirements.

a. Value Based Purchasing

The purpose of AHCCCS' Value Based Purchasing (VBP) Initiative is to encourage contracted MCO activity in the area of quality improvement, specifically to develop initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the MCO and provider through VBP strategies. VBP strategies align payment more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across dimensions of quality. There is a VBP initiative specific to each AHCCCS line of business. In general, contracted MCOs are eligible for a quality payment if they meet the quality performance measures and the value of provider payments criteria that are governed by an acceptable VBP arrangement, also known as an alternative payment model (APM). For example, the acceptable APMs for the acute care MCOs include pay for performance, shared savings, bundled payment, and capitation. For contract year ending 2018, the criterion for the value of provider payments under VBP arrangements is 50% of total provider payments made.

Central to the AHCCCS VBP strategy is the emphasis on flexibility and innovation expected of contracted MCOs. Statewide APMs have not been mandated and each MCO has developed their VBP initiatives to meet the needs of the communities they serve and to best leverage the capabilities of their provider networks to achieve the best member outcomes. AHCCCS employs system-wide VBP strategies in addition to the VBP Initiative. For example, contracted MCOs have target measures for rates of electronic prescribing in their respective provider networks.

b. Value Based Payment (VBP) Differential

Hospitals, nursing facilities, and physicians, physician assistants and registered nurse practitioners that meet Agency established value based performance metrics receive a VBP

Differential Adjusted Payment. AHCCCS is implementing these VBP Differential Adjusted rates to assure that payments are consistent with efficiency, economy, and quality of care.

c. Differential Adjusted Payments (DAP)

The State of Arizona is using §438.6(c)(1)(iii)(B) to provide a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The uniform percentage adjustment represents a positive increase to the AHCCCS Fee-For-Service rates. The purpose of the Differential Adjusted Payment is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. These fee schedule adjustments will be limited to dates of service in CYE 2018 (October 1, 2017 – September 30, 2018).

AHCCCS MCOs will be mandated by contract to provide the same Differential Adjusted Payment increases to their contracted rates to match the corresponding AHCCCS Fee-For-Service rate increase percentages for qualifying providers.

5.2 Targeted Investment

The integration of physical and behavioral health is essential to the AHCCCS strategic goal of reducing system fragmentation. The Targeted Investments (TI) Program provides financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, MCOs are required to provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and Behavioral Health care for Medicaid beneficiaries. The TI Program aims to:

- Reduce fragmentation that occurs between acute care and behavioral health care
- Increase efficiencies in service delivery for members with behavioral health needs
- Improve health outcomes for the affected populations

The provider types that are eligible to participate in the TI Program include:

- outpatient behavioral health clinics
- integrated clinics
- primary care practices, including pediatricians, internal medicine practices, family practices, RNs and nurse practitioners
- hospitals

Financial incentives are paid on an annual basis to participating provider practices, organizations and hospitals based on requirements that vary over the five years of the Targeted Investments Program.

For Year 1 of the TI Program (October 1, 2016-September 30, 2017), participating TI providers are eligible to receive payment following acceptance into the program. For Years 2 and 3 directed incentive payments will be tied to completing Core Components and related milestones. For Years 4 and 5 payments will be based on meeting or exceeding performance improvement targets for specified quality measures. The Core Components include the systems and process requirements that are intended to help further integration of primary care and behavioral health, and those requirements that TI participants must complete to receive incentive payments. They are organized into Adult Primary Care Practice (PCP), Adult Behavioral Health (BH), Pediatric PCP, Pediatric BH, Justice, and Hospital Areas of Concentration.

The overall focus of the Core Components and Milestones is on identifying high risk AHCCCS members with behavioral health needs and connecting them to appropriate resources and services through enhanced care management and data sharing through both primary care and behavioral health providers. For example, Core Components common to several Areas of Concentration include establishment and utilization of a high risk registry, utilization of care managers for individuals listed on the high risk registry, use of an integrated care plan, and use of protocols for two way transmission of admission-discharge-transfer information through the statewide health information exchange. It is believed these actions will improve care coordination and care outcomes. For TI Years 4 and 5, TI participants will receive incentive payments based on their performance on clinical outcome measures.

The measures are intended to assess the effectiveness of the systems of care established through implementation of the Core Components in the earlier years of the Project. The measures are in process of being selected. It is anticipated they will be selected from sources such as HEDIS and the Medicaid Core Measures, and will align with the AHCCCS quality measures.

5.3 CMS Pre-Print Quality Criteria and Framework

Annually, AHCCCS is responsible for preparing CMS Pre-prints for the following payment arrangements: Differential Adjusted Payments (DAP), Targeted Investments (TI), Access to Professional Services Initiatives (APSI) and Nursing Facilities (NF). AHCCCS is required to identify quality criteria and framework for each payment arrangement. Currently, AHCCCS is using the Agency's Strategic Plan to adhere to this requirement; this will change with the posting of the 2018 Quality Strategy. The core elements for the Pre-prints are as follows, AHCCCS:

- Must provide a hyperlink to the State's quality strategy consistent with §438.340(d). AHCCCS must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, AHCCCS' quality strategy must be provided with each Pre-print.
- Is required to make the following assurance: In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.
- Must identify the goals and objectives that the payment arrangement is expected to advance.
- Must describe how the payment arrangement is expected to advance the goals and objectives.
- Is required to make the following assurance: In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.
- Must describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) for the quality strategies identified. For any year other than year one of a multi-year effort, AHCCCS must describe evaluation findings from prior years and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If available, AHCCCS may also attach an evaluation plan or design for each payment arrangement or evaluation findings or reports.

- Is required to indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, a brief description of the payment arrangement's target population must be provided. This could include demographic information such as age or gender, clinical information such as most or MCO enrollment size.
- Is also required to describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

6. Process for Quality Strategy Review and Revision

AHCCCS established the 2017 Quality Strategy Workgroup with the goal of rebuilding its Quality Strategy to include the following:

- Outline significant changes faced by the Agency over the past five years
- Summarize ongoing Agency initiatives
- Outline future goals and objectives, and
- Incorporate the updated Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations

This workgroup consisted of a Core Team tasked with the oversight and management of the organization's efforts to completely overhaul this document, providing a robust and comprehensive program description and evaluation plan that supports the quality focused Managed Care Regulations, with necessary approvals and posting on the AHCCCS website completed no later than July 1, 2018. AHCCCS Executive Management provided essential guidance and feedback related to the structure and contents of the document, serving as the 2017 Quality Strategy Workgroup authority. In addition, an Extended Team comprised of AHCCCS personnel identified as Subject Matters Experts (SMEs) was established to document and highlight key aspects for meeting the before mentioned goals.

Throughout the 2017 Quality Strategy Workgroup efforts, AHCCCS attempted to engage and solicit feedback from external stakeholders and, when possible, incorporated the feedback offered into the development, review, and revision efforts used to create the finalized AHCCCS Quality Strategy. Examples of external stakeholder feedback opportunities built into the project management timeline included, but were not limited to, the following:

- Tribal Consultation Meetings - meetings are held to consult with tribes, Indian Health Service, tribal health programs operated under P.L. 93-638, and urban Indian health programs in Arizona on policy and programmatic changes that may significantly impact American Indian AHCCCS and KidsCare members as well as Indian Health Service (IHS), tribal programs operated under P.L. 93-638, and urban Indian health programs;[4]
- Arizona Long Term Care Services (ALTCS) Advisory Committee - assists the ALTCS Program to develop a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS Members. Council Members will advise on activities aimed at making the system improvements. Individual Council Members are

[4] https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html

asked to provide input and feedback on ALTCS program activities from their own personal or professional experience, expertise or perspective;[5]

- Statewide Medicaid Advisory Committee (SMAC) - reviews and advises the AHCCCS on the operations, programs, and planning for Arizona's Medicaid program. The SMAC advises the Director of AHCCCS on policy, operations and administrative issues of the Medicaid program, including issues of concern to the community. The SMAC operates in accordance with 42 CFR 431.12 (Code of Federal Regulations) and the State Medicaid Plan;[6]
- Public Comment – 45 day public comment period - seeking public input, as posted online with notification distribution occurring through a list serve public notice system.

In addition, AHCCCS involved the Managed Care Organizations (MCOs) throughout the Quality Strategy development process via written communication and discussion at various meetings which included:

- Quarterly Maternal Child Health (MCH) and Early Periodic Screening, Diagnostic and Treatment (EPSDT) MCO Meetings - meetings conducted in collaboration with the AHCCCS Quality Management and Quality Improvement staff that involves ongoing participation of the MCO Quality focused staff members
- Quarterly Regional Behavioral Health Authority (RBHAs) QM Coordinator Meetings - meetings focused on the collaborative nature of quality management and improvement, by involving the mental health consumer and advocacy community, along with Quality Management staff from RBHAs and MCOs
- AHCCCS MCO Update Meeting - meetings to interact with AHCCCS leadership; the Agency hosts the AHCCCS Managed Care Organization (MCO) Update Meetings with contracted MCOs and state agencies, and Regional and Tribal Behavioral Health Authorities (RBHAS/TRBHAS). These meetings are typically held every two months[7]
- AHCCCS Medical Directors Meeting - meeting every other month with all the Chief Medical Officers of AHCCCS MCOs; topics range meeting to meeting from updates by agency area leads to proposed topics from the medical directors

6.1 Establishing Realistic Outcome-Based Performance Measures

AHCCCS establishes minimum performance standards, goals, and benchmarks based on national standards, such as the NCQA National Medicaid means, whenever possible. MCOs are expected to achieve the minimum performance standard for performance measures. Performance measure reports, (i.e. Immunizations), may compare the MCOs' results with each other and with Medicaid and commercial health plan national averages. The rationale for establishing these measures is for MCOs to develop methods to continuously increase the well-being of their respective populations through the removal of barriers to care and ongoing process improvement. AHCCCS participates in national efforts focused on developing Medicaid and CHIP Core Measures to allow comparability across States' programs.

[5] AHCCCS. (n.d.) Arizona Long Term Care System (ALTCS) Advisory Council
[6] https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/smac.html
[7] https://www.azahcccs.gov/PlansProviders/HealthPlans/meetingsevents.html

Each MCO is expected to conduct Performance Improvement Projects (PIPs) in clinical care and non-clinical areas that are expected to have a favorable impact on health outcomes and member satisfaction. Utilizing financial, population, and disease-specific data and input from the MCOs, AHCCCS selects an indicator of performance improvement to be measured across MCOs. For each AHCCCS-mandated PIP, AHCCCS develops a methodology to measure performance in a standardized way across MCOs and manages data collection and analysis. In this way, AHCCCS ensures that the project is implemented by MCOs as well as by other stratifications and for the program overall. In addition, MCOs are required to review their data and quality measures to determine MCO-specific Performance Improvement Projects.

6.2 Sharing Best Practices

AHCCCS actively seeks to identify local, state, and national evidence-based best practices that promote and support member health outcomes. This includes AHCCCS MCO initiated programs and practices as identified by AHCCCS or self-reported by the MCO via the Quality Management and Process Improvement (QM/PI) Program Annual Plan submission. Identified best practices are shared with the External Quality Review Organization (EQRO) for inclusion within the Annual External Quality Review Report.

MCO representatives are invited to share best practices at Quarterly Maternal Child Health (MCH) and Early Periodic Screening, Diagnostic and Treatment (EPSDT) MCO Meetings and Quarterly Quality Management Coordinator Meetings to facilitate discussion and system wide process improvement efforts within the practice area being addressed. In addition, AHCCCS routinely invites external guests to present regarding their expertise specific to key AHCCCS initiatives. Technical assistance is offered upon MCO request or upon AHCCCS direction based on MCO performance.

6.3 Managed Care Organization (MCO) Requirements

AHCCCS requires MCOs, as specified in contract and in AHCCCS Policy, to provide members with information including, but not limited to the following:

- Covered services
- How to obtain services
- How to choose a provider
- A member's rights with respect to grievances and state fair hearings
- Prior authorization processes and requirements
- Advance directives
- What constitutes an emergency
- Language and cultural competency requirements
- Member financial responsibilities
- This information is required to be included in each MCO's Member Handbook, AHCCCS Policy 406, Member Handbook and Provider Directory, Attachment A, outlines all requirements for member handbooks.

The contracts between AHCCCS and its MCOs define the standards for access, structure, operations, and quality measurement and improvement. The AHCCCS Medical Policy Manual (AMPM) and AHCCCS Contractor Operations Manual (ACOM), as well as, other AHCCCS

Policies and Manuals are incorporated by reference as part of the MCO contracts and provide more detailed standards information and requirements.

Requirements for enrollee information dissemination [42 CFR 438.10 and 42 CFR 457.110] as set forth for both AHCCCS and its MCOs are adhered to; moreover, the information specified in Section II (A) (3) of this text, AHCCCS processes and protocols ensure that:

- The Application for Benefits complies with the information requirements for potential enrollees,
- The eligibility staff has access to the provider listing by MCO for their Geographic Service Area (GSA) and will share the MCO's websites with the applicant,
- All enrollees and potential enrollees are informed of their enrollment rights as they pertain to their specific GSA and circumstances,
- The beneficiary support system is available for all enrollees and potential enrollees to assist in making an informed decision when selecting their MCOs.

When enrollees and potential enrollees need help selecting a health plan, they may:

- Visit www.azahcccs.gov/choice; or
- Speak to a Beneficiary Support Specialist by calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800)-334-5283 from area codes (520) and (928).
- AHCCCS also provides links to the AHCCCS MCO web sites, member handbooks, provider searches and drug formularies. This enables applicants to view the MCO networks from the AHCCCS web site.

Vital documents are available in English and Spanish. Spanish is currently the only prevalent non-English language in Arizona. Bilingual staff are available in key areas, and AHCCCS has a contract with Language Line Solutions to facilitate oral interpretation of other languages. When necessary, additional communication accommodations are provided for applicants who have visual, auditory, and/or other impairments. In addition, vital documents include taglines in the other non-English languages, as well as large print, providing the contact information for assistance.

6.4 Regular Monitoring and Evaluation of MCO Performance

AHCCCS monitors and evaluates MCO compliance through Operational Reviews (ORs), the review and analysis of periodic reports as required in contract, program specific Performance Measures, and Performance Improvement Projects. Objectives of MCO monitoring and evaluation include:

- Determine if the MCO satisfactorily meets AHCCCS requirements as specified in Contract, AHCCCS policies, Arizona Revised Statute, Arizona Administrative Code and 42 CFR Part 438, Managed Care.
- Increase knowledge of the MCO's operational encounter processing procedures.
- Provide technical assistance and identify areas where improvements can be made, as well as to identify areas of noteworthy performance and accomplishments.
- Review progress in implementing recommendations made during prior reviews.
- Determine if the MCO is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.

- Perform MCO oversight required by CMS in accordance with the AHCCCS 1115 waiver.
- Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364.

a. On-Site Operational Reviews (ORs)

AHCCCS conducts administrative Operational Reviews (ORs) of each contracted MCO at least every three years, utilizing the process to meet the requirements of the Medicaid Managed Care Regulations (42 CFR 438.364), to determine the extent to which each health plan meets AHCCCS Contract requirements, AHCCCS policies, and additional federal and state requirements. AHCCCS sets standards for operational, programmatic and clinical standards and reviews the MCOs' records, reports, and information systems and interviews key health plan staff information in evaluating the MCOs compliance with each standard. Additionally, AHCCCS staff reviews the progress in implementing the recommendations made during prior ORs, determines each MCO's compliance with its own policies and procedures and evaluates its effectiveness. Agency staff from the DHCM the Office of Administrative and Legal Services (OALS), the Division of Business and Finance (DBF), OIG, and OIFA review the operations of the MCO, conduct file reviews, and interview key health plan staff.

To maintain compliance with regulatory requirements and AHCCCS Contract standards, AHCCCS reviews the following areas (as applicable) at least every three years:

- Case Management
- Corporate Compliance
- Claims and Information Systems
- Delivery Systems
- General Administration
- Grievance System
- Adult, EPSDT, and Maternal Child Health
- Medical Management
- Quality Management
- Reinsurance
- Third Party Liability

Upon completion of an Operational Review, MCOs are required to submit corrective action plans (CAPs) in any areas receiving a score of less than 95 percent. AHCCCS expects the vast majority of these CAPs to be implemented and closed within six months of the AHCCCS' acceptance of the CAP. MCOs are required to submit a CAP update along with documentation demonstrating compliance to close each CAP.

AHCCCS may choose to review specific areas more frequently depending on identified need. For example, in 2015, AHCCCS conducted a mid-cycle review in areas identified of heighted concern. AHCCCS also uses the OR to increase its knowledge of each MCO's operational procedures, provide technical assistance and identify areas for improvement, as well as, areas of noteworthy performance and accomplishment.

As a condition of its 1115 Waiver, AHCCCS performs extensive data validation. Known as encounter data, records of services provided are submitted to AHCCCS for all covered services including institutional, professional, dental, and medication/pharmacy services, with each having its own format. AHCCCS also performs annual validation studies on MCO data to ensure that the data has been reported in a timely manner, is accurate and complete. Since sanctions may be imposed on the MCO, based on the results of the data validation studies, AHCCCS provides technical assistance and training to the MCOs to support the MCO's ability to meet AHCCCS requirements. OR and data validation results are reported to CMS in accordance with the 1115 Waiver Terms and Conditions.

b. Grievance and Appeals

One of many critical objectives of the Agency's grievance and appeals system is to advance and improve the quality, accessibility, and timeliness of health care services for AHCCCS members. AHCCCS has developed robust contractual requirements, which have been refined over the years. Contracts dictate member-focused standards designed to ensure MCO provide members with timely and medically necessary health care services, focusing on improvements in their health and well-being. In addition to detailed contractual requirements that promote these objectives, AHCCCS has also promulgated specific administrative regulations and clarifying policies to which MCOs must adhere.

The Office of Administrative Legal Services (OALS) is responsible for oversight of the Title XIX Grievance and Appeals system and the Grievance and Appeals system for members determined to have a SMI, it continually engages in review of hearing cases resulting from appeals of adverse benefit determinations from managed care beneficiaries. Not only does AHCCCS monitor the number of beneficiary hearing requests filed against each MCO on a monthly basis, AHCCCS also reviews the appeal types of adverse benefit determinations to identify trends, outliers, and whether additional scrutiny of the MCO's service authorization process may be warranted. As mandated by 438.402, MCOs are permitted only one level of appeal.

Routinely, the Agency's medical management department receives a listing of beneficiary requests for hearing from OALS in order to review adequacy of service authorization notices sent to beneficiaries pursuant to 42 CFR 438.404. Equally as important, each substantive hearing case resulting from the appeal of an adverse benefit determination is individually reviewed to evaluate MCO compliance from both a procedural standpoint and a clinical perspective. This scrutiny includes consideration of the MCO's handling of grievances and appeals pursuant to 42 CFR 438.406 to ensure beneficiary access, meaningful participation, and effective MCO review. When deficiencies or concerns are identified, including those that pertain to quality of service, accessibility of service, and timeliness of service or the adequacy or timeliness of the MCO notifications pursuant to 42 CFR 438.404 and 408, they are highlighted in the hearing decision.

Deficiencies and areas of concern are communicated to appropriate divisions within the Agency to be addressed. As a result, compliance actions may be instituted against MCOs, and corresponding policies may be developed or amended. All hearing matters that present quality of care concerns regarding service delivery, accessibility, or timeliness, are referred to the Agency's quality management department for thorough investigation. In addition, findings from OALS' reviews of MCO hearing cases and member concerns directed to OALS are communicated

within quarterly meetings to executive and management staff across the Agency. These quarterly meetings are convened to evaluate MCO performance in a variety of operational areas. As part of the Agency's continuing scrutiny of MCO quality, timeliness, and accessibility of health care delivery to members, staff from OALS participate in ongoing operational reviews of each MCO's grievance and appeals system. The purpose is to determine MCO compliance with member Grievance and Appeals requirements.

A meaningful recordkeeping system is vital and fundamental to an effective grievance and appeals system. Thus, consistent with 42 CFR 438.416, each MCO must comply with detailed recordkeeping requirements for all grievances and appeals in order to inform their ongoing monitoring processes and the continual refinement of their quality strategies. Through its operational reviews and oversight activities, AHCCCS assess each MCO's recordkeeping system to determine their efficacy.

c. Intermediate Sanctions that Meet the Requirements of Sub-Part I

AHCCCS may impose monetary sanctions, suspend any or all further member enrollment, and/or suspend, deny, refuse to renew or terminate a Contract in accordance with Arizona Administrative Code, R9-22-606, and the terms of the Contract and applicable Federal or State regulations. Written notice is provided to the MCO specifying the sanction to be imposed, the grounds for the sanction, and either the length of suspension or the amount of capitation prepayment to be withheld. The MCO may appeal the decision to impose a sanction in accordance with 9 A.A.C. 34. Intermediate sanctions may be imposed for, but are not limited to the following actions:

- Substantial Failure to provide medically necessary services that the MCO is required to provide, under the terms of its AHCCCS Contract, to its enrolled members.
- Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
- Discrimination among members on the basis of their health status or need for health care services.
- Misrepresentation or falsification of information furnished to CMS or AHCCCS.
- Misrepresentation or falsification of information furnished to an enrollee, potential enrollee or provider.
- Failure to comply with the requirement for physician incentive plan as delineated in contract.
- Distribution directly, or indirectly, through any agent or independent contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information.
- Failure to meet quality of care and quality of management requirements.
- Failure to meet AHCCCS encounter standards.
- Violation of other applicable state or federal laws or regulations.
- Failure to fund accumulated deficit in a timely manner.
- Failure to increase the Performance Bond in a timely manner.
- Failure to comply with any other contract provisions.

AHCCCS may impose the following types of intermediate sanctions:

- Civil monetary penalties.
- Appointment of temporary management of a MCO.
- Allowing members to right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
- Suspension of all new enrollment, including auto assignments.
- Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Additional sanctions to allow under statute or regulation that address areas of noncompliance.

d. Ongoing Review and Analysis of Deliverables

Contract deliverables are due weekly, monthly, quarterly, annually and on an ad hoc basis depending on the individual deliverable requirement. A chart of Contract deliverables is included in the MCO Contract; these deliverables may vary depending on the line of business. To monitor compliance with Rules, Regulations, Contracts and policies on an ongoing basis, MCOs are required to submit a number of Contract deliverables. These deliverables include, but are not limited to:

- Case Management Plan
- Cultural Competency Plan and Assessment
- Grievance and Appeal System Report
- EPSDT Plan and Evaluation
- Maternity Care Plan and Evaluation
- Medical Management Plan, Evaluation and Work Plan
- ALTCS Member Council Plan
- Provider Network Development and Management Plan
- Quality Assessment/Performance Improvement Plan and Evaluation
- Quality Management Quarterly Reports
- Credentialing Quarterly Reports
- Gap in Critical Service Reports (for Attendant Care, Personal Care, Housekeeping and Respite Care services)

e. Annual Plans

AHCCCS requires MCOs to submit Annual Plan reports, which delineate implementation of their comprehensive approach for ensuring that high quality and cost effective services are provided for all Medicaid members within Arizona, including those with special health care needs and behavioral health issues. A distinct set of Annual Plan reports summarize general QM/PI and MM strategies, as well as population specific requirements for Early Periodic Screening, Diagnostic and Treatment (EPSDT) services mandated under CMS. RBHAs must submit an Integrated Plan Report, in addition to an Annual Plan, which outlines efforts toward integration of physical and behavioral health care for all members.

Each MCO is required to submit separate reports for Medical Management, Quality Management/Performance Improvement, and EPSDT services mandated under CMS (EPSDT includes the Annual Plan, a Dental Plan and a Maternity/Family Planning Plan). Each of these reports must include a Narrative Plan, a prospective Work Plan and a Work Plan Evaluation. The Narrative plan must identify operational and structural elements that will ensure achievement of contractually required clinical, quality and performance elements for all members under the care of an MCO or RBHA. Prospective Work Plans focus on goals and methods for achieving performance and quality standards for the upcoming contract year. Work Plan Evaluations offer an analysis of the previous year's activities related to quality and performance goals and strategies.

f. Quarterly Reports

MCOs are required to submit an EPSDT and Adult Quarterly Monitoring Reports to the AHCCCS Quality Improvement Team. These quarterly deliverables provide self-reported MCO data relative to essential EPSDT services and referrals, member and provider outreach, and contractually required performance measures. The MCOs include, within these reports, an analysis of the data that addresses effectiveness of monitoring. Components include coordination of care, follow-up, and other interventions made as a result of the reported performance. If there are significant changes in any area, the MCO is to address the possible causes and planned interventions to improve performance.

In an effort to align MCO reporting across lines of business, the EPSDT and Adult Quarterly Monitoring Report template, general and specific reporting instructions were revised to provide essential guidance to effectively compare performance. In addition, a consolidated reporting format was created to facilitate efficient AHCCCS Quality Improvement staff review of EPSDT and Adult Quarterly Monitoring report submissions; format changes also expedited feedback given to providers.

g. Meetings and Staffings

AHCCCS routinely conducts quality driven meetings that facilitate staff education and the wide-spread dissemination of quality-related information specific to MCO performance. These meetings include, but are not limited to, the following:

- Clinical Oversight Committee – quarterly meetings facilitated and managed by the Clinical unit which, include the AHCCCS Director, Executive Management and representatives from across Division conducted to review MCO clinical and quality performance and discuss and review clinical initiatives.
- Operations Oversight Committee - quarterly meetings facilitated and managed by the Operations unit which includes the AHCCCS Director, Executive Management and representatives from across Division conducted to review MCO operational and financial performance.
- Quarterly Quality Management MCO Meeting – quarterly meetings facilitated by Clinical unit which includes representatives from MCO Quality, MCH/EPSDT, and Behavioral Health teams as well as Agency staff to review quality objectives, policies and procedures, and provide resources and guest speakers who support overall quality efforts.

6.5 Performance Measures

AHCCCS has developed and implemented performance metrics to monitor MCO compliance in meeting contractual requirements related to the delivery of care and services to members. In developing the metric performance measure set, attention was paid to the goals coined by the Institute for Health Improvement (IHI) and adopted by CMS, which is called the "Triple Aim for Populations". IHI defines the Triple Aim as "a framework for optimizing health system performance". As referenced in Section 3 of this document, the AHCCCS Quality Strategy is based firmly in the Triple Aim concepts for quality and effective health care delivery.

AHCCCS Performance Measures (PMs) are based on CMS Core Measure Sets, National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures, Substance Abuse and Mental Health Services Administration (SAMHSA) quality measures, and other resources. AHCCCS PMs are integral to each MCO's QM/PI Program and may focus on clinical and non-clinical areas. MCOs are required to report on PMs as identified in contract. MCOs that provide LTSS will also include LTSS-specific PMs that examine, at a minimum, members' quality of life and the MCO's rebalancing and community integration outcomes. Performance measures specific to member's selecting a self-directed option may also be developed. The measures will consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. PMs are also evaluated based on a number of demographics in order to reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The measures will support and align with the MCO's QM/PI Program [42 CFR 438.330(c)(1)(ii)].

The AHCCCS Performance Measures are used to evaluate whether MCOs are fulfilling key contractual obligations. Such performance measures, established or adopted by AHCCCS, are also an important element of the Agency's approach to transparency in health services and value-based purchasing. MCO performance is publicly reported on the AHCCCS website (e.g. report cards and rating systems) plus other means, such as sharing of data with state agencies and other community organizations and stakeholders. MCO performance is compared to AHCCCS requirements, national Medicaid health plan means, and goals established by CMS.

6.6 Performance Improvement Projects (PIPs)

AHCCCS mandates that MCOs participate in PIPs selected by the Agency. MCOs also may select and design, with AHCCCS approval, additional PIPs specific to needs and data identified through internal surveillance of trends. PIPs are developed according to 42 CFR 438.330, Quality Assessment and Performance Improvement Program, and designed to correct significant system problems (e.g. increased use of e-prescribing) and/or achieve significant improvement in health outcomes (e.g. increased rate of developmental screening for 1-, 2-, and 3-year old members) as well as enrollee satisfaction, that is sustained over time, through the:

- Measurement of performance using objective quality indicators
- Implementation of interventions to achieve improvement in access to and quality of care
- Evaluation of the effectiveness of the interventions based on the performance measures

- Planning and initiation of activities for increasing or sustaining improvement [42 CFR §438.330(d)(2)]

AHCCCS mandated PIP topics are selected through analysis of internal and external data/trends and may include MCO input. Topics take into account comprehensive aspects of member needs, care and services for a broad spectrum of members or a focused subset of the population including those members with special health care needs or receiving LTSS(42 CFR §438.330). AHCCCS may also mandate that a PIP be conducted by a MCO or group of MCOs, according to standardized methodology developed by AHCCCS. CMS may, in consultation with states and other stakeholders, specify standardized performance measures and topics for PIPs for inclusion alongside of state-specified performance measures and PIP topics in state contracts [42 CFR §438.330(a)(2)]. MCOs are required to conduct Performance Improvement Projects, including PIPs required by the CMS that focus on both clinical and nonclinical areas.

6.7 Improvement/Interventions

Within the quality review structure, evaluation team members seek to determine if a substantial change was made toward meeting the identified target area(s). For notable improvements, associated interventions that are directly linked to the improvement itself are considered as possible best practices that can be shared amongst MCOs, thus allowing for a greater overall improvement opportunity.

a. Review and Analysis of Program Specific Performance Measures and Performance Improvement Projects

On a regular basis, AHCCCS reviews results by MCO for the quality management Performance Measures. Results are compared with minimum performance standards specified in contract, and trends are identified. Results of measurements for Performance Improvement Projects are also reviewed and analyzed by MCO. Appropriate action, such as requiring MCOs to implement corrective action plans and/or providing technical assistance to the MCO, is conducted depending on findings. Results are also analyzed by line of business (e.g. Acute, Long Term Care, Behavioral Health, Developmental Disabilities, etc.) and at the AHCCCS aggregate level when possible, to identify systemic opportunities for improvement.

b. Quality Rating System

In accordance with 42 CFR 438.334 – Medicaid Managed Care Quality Rating System, AHCCCS began enhancing its MCO Report Card to serve as the Agency's preferred alternative Medicaid managed care quality rating system.

- MCO Report Card - Prior to Contract Year 2018, the AHCCCS MCO Report Card reflected the performance of the MCOs contracted to provide services under the Acute Care Line of Business through the use of various quality data elements including: Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, and performance measures rates and several business operations metrics.
- The AHCCCS MCO Report Card was enhanced based on internal and external stakeholder feedback. The updated MCO Report Card is posted on the AHCCCS website.
- Contract Year 2018 updates include the expansion of the report card to other lines of business including:

- Arizona Long Term Care Services/Developmental Disabilities (ALTCS/DD)
- Arizona Long Term Care Services/Elderly Physically Disabled (ALTCS/EPD)
- Comprehensive Medical and Dental Program (CMDP)
- Regional Behavioral Health Authority (RBHA)

- Additional components include a Resources/Links section that provides easier access to specific MCO related quality documents (e.g. published External Quality Review Reports and full length CAHPS survey results).
- AHCCCS recently initiated additional updates geared towards further enhancing the overall appearance and ease of use, as well as providing increased transparency and a vehicle to assist members in health plan selection. This includes:
  - Interactive Star Rating system specific to Performance Measure Rates and Overall Health Plan Responsiveness
  - Availability of the MCO Report Card in both English and Spanish

7.0 Medical Quality Assessment and Performance Improvement Requirements

Within its MCO Contracts, AHCCCS outlines Quality Assessment and Performance Improvement Projects, in accordance with applicable CMS regulations, as well as, state and federal rules and regulations. These requirements include, but are not limited to:

- Identification, assessment, care coordination, and provision of appropriate care and services for members with special care needs
- Execution of processes for assessing, planning, implementing, and evaluating Quality Management and Performance Improvement (QM/PI) activities
- Integration of quality management processes, such as tracking and trending of issues, throughout all areas of the organization
- Implementation and maintenance of an ongoing quality management program for the services furnished to members that includes:
  - A written QM/PI plan and an evaluation of the previous year's QM/PI program.
  - Quality management quarterly reports that address strategies for QM/PI activities.
  - QM/PI program monitoring and evaluation activities which include Peer Review and Quality Management Committees which are chaired by the MCO's local Chief Medical Officer.
  - Protection of medical records and any other personal health and enrollment information that identifies a particular member, or subset of members, in accordance with Federal and State privacy requirements.
  - Member rights and responsibilities [42 CFR 238.100(b)(2)(iv)].
  - Uniform provisional credentialing, initial credentialing, re-credentialing and organizational assessment verification [42 CFR 438.206(b)(6)]; the MCO shall demonstrate that its providers are credentialed and reviewed through the MCO's Credentialing Committee that is chaired by the MCO's local Medical Director [42 CFR 438.214].

- Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, abuse, neglect, exploitation and unexpected deaths.
- Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO).
- Performance improvement programs including performance measures and performance improvement projects.

AHCCCS Quality Improvement staff work collaboratively with the AHCCCS Contract staff to ensure contractual requirements are reviewed and updated at a minimum of once per year, or as needed. The purpose of these reviews is to ensure the reporting of targeted information and quality metrics align with the AHCCCS Strategic Plan and Quality Strategy.

7.1 Assessment of Quality and Appropriateness of Care/Services for Routine and Special Health Care Needs Members

MCOs are required by contract to identify children and adults with Special Health Care Needs (SHCN). The qualifying criteria is defined in contract as members with special health care needs who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member is considered as having special health care needs, if the medical condition simultaneously meets the following criteria:

- Actively engaged in a transplant process plus one year post transplant
- ALTCS/DDD
- ALTCS/EPD
- Autism/At risk for Autism
- Arizona Early Intervention Program (AzEIP)
- CMDP and up to one year after transition from CMDP
- CRS ECSII/CASII score of 4 or higher
- High needs and high costs HIV/AIDS
- SCIDs
- SED/NAS
- SMI

Identification

Members with SHCNs are identified in a number of ways, such as, through review of utilization data to identify diagnoses, services and medications specific to a member with a SHCN, new member health risk assessments, concurrent review, prior authorization and review of EPSDT tracking forms. The identification (not available for all categories of SHCN) that designates a member as having a SHCN is entered into AHCCCS' mainframe known as Pre-paid Medical Management Information System (PMMIS).

Assessment

MCOs are required to comprehensively assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member that require a course of treatment, regular care management, or transition to another AHCCCS program [42 CFR 438.208(c)(2), 42 CFR 438.240(b)(4)]. The assessment mechanisms must use appropriate health care professionals with the appropriate expertise [42 CFR 438.240(c)(2)] [42 CFR

438.208(c)(2)]. The MCO must share, with other entities providing services to that member, the results of its identification and assessment of that member's needs to avoid unnecessary duplication of effort [42 CFR 438.208(b)(4) and (c)(3)].

The MCO must ensure that members with special health care needs have an individualized clinical and behavioral treatment or service plan. Further, the MCO shall conduct multi-disciplinary staffings for members with challenging behaviors or health care needs [42 CFR 438.208(c)(3).

Access to Care

AHCCCS recognizes that Medicaid members with special health care needs or chronic health conditions require care coordination and AHCCCS requires MCOs to provide appropriate coordination. MCOs must have Care Management staff who are located in Arizona and who provide care coordination for members with special health care needs. For members with special health care needs, determined to need a specialized course of treatment or regular care monitoring, the MCO must have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits). Procedures must be appropriate for the member's condition and identified needs [42 CFR 438.208(c)(4)]. For members transitioning, see Section D, Paragraph 8, Transition Activities. Additionally, the MCO must have a methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access to these providers.

Monitoring

AHCCCS monitors quality and appropriateness of care/services for routine and special health care needs members through annual Operational Reviews of MCOs and the review of required MCO deliverables set forth in Contract, program specific performance measures, and performance improvement projects. AHCCCS tracks and trends member grievances to identify potential access to care issues and/or the need for corrective actions; and monitors the outcomes of required corrective action

7.2 Sanction Philosophy and Notice to Cure

AHCCCS collaborates closely with its MCOs to ensure compliance with contractual and policy requirements and provides technical assistance whenever necessary to assist a MCO with education and training on specific requirements. AHCCCS does have the authority to issue Administrative Actions and Sanctions for failure of an MCO to demonstrate compliance with contractual requirements. Each occurrence of non-compliance will be evaluated for determination of issuance of potential administrative action. Administrative Actions may include issuance of any of the following: Notice of Concern, a mandate for Corrective Action Plan, Notice to Cure and/or Sanctions.

With few exceptions, the AHCCCS Compliance Committee evaluates recommendations for proposed sanctions and determined the appropriate sanction to be imposed after consideration of relevant factors. The Compliance Committee may also review Administrative Actions that do not include a sanction, such as a Notice of Concern, Notice to Cure or requirement of a Corrective Action Plan. AHCCCS ACOM Policy 408, Sanctions, describes the types of sanctions and subsequent monetary penalties or other actions that may result if a MCO fails to adhere to the provisions of the Medicaid Managed Care program or Contract requirements. The policy also

identifies the committee membership and considerations for determination of appropriate sanctions.

8. Enabling Infrastructure: Data and Technology Systems

AHCCCS performs extensive data validation of managed care data. Records of services provided, known as encounter data, are submitted to the Agency for all covered services including institutional, professional, dental, and medication/pharmacy services, in standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) and National Council for Prescription Drug Programs (NCPDP) formats, and are subject to extensive data standards and data quality editing. AHCCCS also performs annual validation studies on MCO encounter data to ensure that the data has been reported in a timely manner, and is accurate and compete.

8.1 Pre-paid Medical Management Information System (PMMIS)

AHCCCS operates a mainframe processing system known as Pre-paid Medical Management Information System (PMMIS). PMMIS is made up of multiple sub-systems, each with a distinct function supporting Managed Care, as well as Fee-For-Service processes. Sub-systems are interrelated and share common data and many processing rules. AHCCCS maintains Medicaid eligible members in the Recipient System where Members are assigned to an MCO based on enrollment rules, choice or the auto assignment algorithm, registration files for all providers eligible for participation in the AHCCCS program, and Reference data intended to support timely and accurate processing.

AHCCCS collects encounter data from all MCOs. An encounter is a record of a medically related service rendered by a registered AHCCCS provider to an AHCCCS member enrolled with an MCO on the date of service by that MCO. Ensuring complete, accurate and timely reporting of encounter data is critical to AHCCCS' success. MCOs are required to submit encounters for services provided to AHCCCS members for paid services, services eligible for processing with no financial liability (e.g. Medicare, third-party payer), prior period coverage (PPC) and administrative denials. AHCCCS Encounter formats follow national industry standards and code sets for encounter submissions and editing (837P/I/D and NCPDP Post Adjudicated History). All submitted encounters are subject to AHCCCS specific requirements as well as approximately 500 edits/audits including Federal coding standards (e.g. correct coding and medically unlikely edits). Data validation occurs in both a structured/formal process and on an ad hoc basis and includes review by certified coders to ensure that encounter data is complete, accurate and timely. Actuaries perform ad hoc analysis, minimally, at each rate-setting period and Operational/Actuarial reports measure MCO Encounters throughput by date of service and date of submission.

8.2 COGNOS/Data Warehouse

The agency has established a data warehouse known as the AHCCCS Data Warehouse, which provides a timely and flexible way to monitor and provide analytics for performance measure data. Utilization data may be reviewed by multiple characteristics, such as diagnosis, service, age, gender or another characteristic type based on the area under construction. The Data Warehouse (DW) is an additional system that is maintained by an in-house team of business analysts, programmers and configuration specialists. Both are maintained on an ongoing basis, according to quarterly periodicity schedule. AHCCCS staff monitors and complete additions or

changes according to policy, legislative, CMS or other requirements. Requests for system changes, additions, or maintenance are forwarded to the AHCCCS Office of Business Information (OBI) or Information Services Division (ISD) for completion of required system updates.

8.3 Health Information Exchange (HIE)

Since 2006, health care stakeholders have been supporting a model of health information exchange where the operator of the health information exchange sits outside of state government and serves as a community resource for all participants. Formerly called Arizona Health-e Connection and now called Health Current, this non-profit organization is a health information exchange organization (HIO) and is the single statewide HIE. Health Current currently has 347 unique participants which include hospitals, Accountable Care Organizations, Health Plans, Behavioral Health providers, laboratories, ambulatory practices, long term care providers and more. For a complete list of participants, Health Current maintains a count on their website: https://healthcurrent.org/hie/the-network-participants/. AHCCCS requires all of its managed care MCOs to join the HIE for the purpose of improving care coordination.

At this time, Health Current has Hospital Admissions, Discharges, and Transfer (ADT) information from 95 percent of all of hospitals in Arizona. Health Current processes over 7 million transactions a month and has 8 million unique patient records in their HIE. Health Current processes laboratory results, radiology reports, and transcription reports in addition to alerts and ADTs. Besides handling this core data set, Health Current continues to work with its stakeholders to meet their larger data sharing needs. As an example, effective 10/1/2017, Arizona providers will be required to check the Prescription Drug Monitoring Program or PDMP, before they can write a prescription for a controlled substance. Health Current just completed the electronic interface with the PDMP to ensure its participants can use the HIE to its new reporting requirements. Health Current is also planning to establish an electronic interface with the Arizona Department of Health Services to link it with the state's Immunization Program and Birth Defects Registry for the reporting of Zika related Birth Defects.

Health Current recently completed an agreement to electronically share hospital data with several out of state HIEs through a project called the Patient Centered Data Home (PCDH). The PCDH project provides the technical and legal agreements to support cross state data sharing for the purpose of care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah and now Santa Cruz and San Diego HIEs are capable of sharing hospital ADT information with a Medicaid member's home HIE, if they seek care outside of their Arizona or "home" HIE.

9. State Verification that Sub-Part E Provisions of the Managed Care Regulations Are Included in Medicaid Contract Provisions

AHCCCS incorporates into its MCO Contracts, the Code of Federal Regulation (CFR) requirements regarding MCO establishment and implementation of ongoing comprehensive quality assessment and performance improvement programs for services provided to members. The Contracts between AHCCCS and its MCOs define the standards for access, structure, operations, quality measurement and improvement. The AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractors Operations Manual (ACOM), as well as, other

AHCCCS policies and manuals, are incorporated by reference as part of the MCO Contracts and provide more detailed standards, information, and requirements.
MCO Contract Provisions include the following MCO requirements:

- Establish and implement an ongoing comprehensive quality assessment and performance improvement program.
- Have mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by the State in the Quality Strategy.
- Conduct performance improvement projects.
- Collect and submit performance measurement data.
- Have mechanisms to detect both underutilization and overutilization of services.
- Have mechanisms to assess the quality and appropriateness of care provided to members with special health care needs.
- Collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and care coordination efforts.
- Track and trend member and provider issues.
- Have written policies regarding member rights and responsibilities.

For MCOs providing Long-Term Services and Supports (LTSS):

- Have mechanisms to assess the quality and appropriateness of care provided to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable.
- Participate in efforts by the State to prevent, detect, and remediate critical incidents.

10. Conclusion

Improving and/or maintaining members' health status, as well as, increasing the potential for resilience and functional health status for members with chronic conditions is at the core of the Quality Strategy. AHCCCS uses a variety of modalities to drive quality through the system to achieve improvements and successes. AHCCCS' culture of quality is sustained by the combination of oversight and collaboration provided in the form of:

- **Operational Reviews (ORs)** - identify accomplishments and areas of improvement. The OR is an effective vehicle for discovering best practices that can be shared with all MCOs. Corrective Action Plans (CAPs) are developed as necessary. CAPs function as a tool to follow up where improvement is needed.
- **Performance Measures** - such as standards for children's dental care and timely prenatal care, which demonstrate an overall improvement in the system and for which corrective measures are implemented, as necessary.
- **Performance Improvement Projects -** for example, improvement in the use of Advance Directives among ALTCS members, as documented in their health records. By documenting one's wishes for end-of-life care, families and physicians are aware of the treatment that a member does or does not want when that person is no longer able to make those wishes known.

- **Collaborative Projects** – for example, the oversight of nursing/Assisted Living Home facilities, which has reduced the burden on nursing/Assisted Living Home facilities by allowing for coordinated efforts of single-entity review (unless quality issues are identified), allowing for more efficient use of resources as well as effective planning strategies by the MCOs.
- **Federal initiatives** - such as the Agency for Healthcare Research and Quality (AHRQ), which is focusing on collaborative opportunities to develop quality-based pay-for-performance programs and value based purchasing. Working with other states and employers in Community Purchasing Groups, AHCCCS is participating in the development of a pay-for-performance program that rewards evidence-based care resulting in quality outcomes to members, and discourages negative outcomes.

Although AHCCCS has experienced significant quality improvements and successes, the Agency and its MCOs continuously strive for:

- Improved performance by MCOs as a result of incentives, such as comparative reporting and financial incentives.
- Informed, health literate members who understand the value of preventive care and for those members with chronic diseases, the ability to maintain or improve their health.
- A physician community that is increasingly vested in the prevention of disease.
- Systematic research and sharing of best practices and lessons learned both locally and nationally.
- A significant reduction in the costs associated with treating disease and adverse health outcomes.
- Broader participation in collaborative community efforts to improve the health status of Arizonans.
- Identification of Centers of Excellence.
- Provision of technical assistance programs with subject matter experts.

The AHCCCS Credo is, ***"Our first care is your health care."*** With the member clearly in mind, AHCCCS has long been respected as an innovator in the area of Medicaid Managed Care. Through the Agency's Mission, Vision and Values, AHCCCS continues to be forward-thinking, driving continuous improvement and innovation. Despite the challenges, AHCCCS is committed to increasing its pro-active role as a "quality of care improver," while maintaining its traditional role as the monitor of quality of care. AHCCCS looks forward to continued partnerships and collaborations in meeting the delivery system challenges of today and tomorrow.

11. Appendix

11.1 Links to Related Documents

AHCCCS MANUALS

1. AHCCCS Contractor Operations Manual (ACOM)
https://www.azahcccs.gov/shared/ACOM/

2. AHCCCS Medical Policy Manual (AMPM)
https://www.azahcccs.gov/shared/MedicalPolicyManual/

AHCCCS REPORTS

1. AHCCCS 1115 Waiver 2016-2021
https://azahcccs.gov/Resources/Federal/waiver.html

2. AHCCCS Five Year Strategic Plan: 2017-2022
https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_17-22.pdf

3. AHCCCS Contracts
https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html

4. AHCCCS Quality & Performance Improvement – Performance Measures and Performance Improvement Projects
https://www.azahcccs.gov/Resources/OversightOfHealthPlans/quality.html

5. External Quality Review Organization Reports
https://www.azahcccs.gov/Resources/Reports/EQR.html

QUARTERLY REPORTS TO CMS

1. https://www.azahcccs.gov/Resources/Reports/quarterly.html

ANNUAL REPORTS TO CMS

2. https://www.azahcccs.gov/Resources/Reports/federal.html

11.2 References

[i] **Jacob's Law, House Bill 2442, Chapter 71, An Act, Amending Section 8-201.01, Arizona Revised Statutes; Amending Title 8, Chapter 4, Article 4, Arizona Revised Statutes, 52nd Leg, 2nd Sess. (2016); [On-line]. Available: http://www.azleg.gov/legtext/52leg/2r/laws/0071.pdf**

[ii] Justice Initiatives: *https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html*

[ii] https://www.huduser.gov/portal/publications/pdf/PhoenixAZ-comp-16.pdf

[iii] https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf
https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/arnold-v-adhs-stipulation-for-providing-community-services-and-terminating-litigation-january-2014.pdf

[iv] Arnold vs. Arizona Department of Health Services, Stipulation for Providing Community Services and Terminating the Litigation, No. C-432355. (Arizona Superior Court, Maricopa County January 8th, 2014). [On-line]. Available: https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/arnold-v-adhs-stipulation-for-providing-community-services-and-terminating-litigation-january-2014.pdf

[v] U.S. Office of Housing and Urban Development, Office of Policy Development and Research. Comprehensive Housing Market Analysis, Phoenix-Mesa-Scottsdale, Arizona (April 1, 2016 pp 1-13). [On-line]. Available: https://www.huduser.gov/portal/publications/pdf/PhoenixAZ-comp-16.pdf

[vi] VI-SPDAT (Vulnerability Index Service Prioritization Decision Assistance Tool)
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/448.pdf

[vii] Housing Quality Standard. [On-line]. Available:
https://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/hqs
The separate reference list identifies issues with this link. See separate reference list (red font)

[viii] CMS rules for HCBS Services